Treatment Progress Indicator: Your Emotional Vital Signs

Last Name | | | | | | | | | | | | | | | | | | |

First Name | | | | | | | | | | | | | | |

Date of Birth | | | / | | / | | |
month *day* *year*

Version 3.0
Office Use Only

MRN | | | | | | | | |

Counselor/Group ID

M	A	R	T	I	N	E	Z

1. How well have you been getting along emotionally and psychologically?
☐ Quite poorly ☐ Fairly poorly ☐ So-so ☐ Fairly well ☐ Quite well ☐ Very well
2. During the past two weeks, how much have you had to cut down on the amount of time you spent on work or other activities as a result of any emotional problems? ☐ Not at all ☐ Cut down a little ☐ Cut down a lot
3. Are you taking medication for a psychological problem? ☐ Yes ☐ No ☐ No, but I've been advised to
4. **In the PAST WEEK**, how often have you had thoughts of harming yourself or someone else? ☐ Never ☐ Sometimes ☐ Often

In the past TWO WEEKS, how OFTEN have you . . .	**Never or rarely**	**Some of the time**	**Often**	**All or almost all the time**
5. . . . felt sad, down, or depressed?	☐	☐	☐	☐
6. . . . felt less pleasure from things you used to enjoy?	☐	☐	☐	☐
7. . . . had trouble concentrating?	☐	☐	☐	☐
8. . . . felt hopeless or pessimistic about the future?	☐	☐	☐	☐
9. . . . felt tense or anxious?	☐	☐	☐	☐
10. . . . worried too much about things?	☐	☐	☐	☐
11. . . . been in places or situations that you fear?	☐	☐	☐	☐
12. . . . had repeated thoughts or images that wouldn't go away?	☐	☐	☐	☐
13. . . . had problems falling asleep, staying asleep, or sleeping too much?	☐	☐	☐	☐
14. . . . had repeated disturbing memories, thoughts or images of a frightening past experience?	☐	☐	☐	☐
15. . . . been dissatisfied with your relationships with others?	☐	☐	☐	☐
16. . . .felt guilty about your alcohol or drug use, or that you should cut back?	☐	☐	☐	☐ ☐ No Use
17. . . .felt your health, work or home life was affected by drinking or drug use?	☐	☐	☐	☐ ☐ No Use
18. . . .had severe mood swings (highs and lows)?	☐	☐	☐	☐

In the past TWO WEEKS, how WELL have you . . .	**Very Well**	**Fairly Well**	**Fairly Poorly**	**Very Poorly**
19. . . . been able to manage your day-to-day life?	☐	☐	☐	☐
20. . . . been able to get along with friends?	☐	☐	☐	☐
21. . . . been able to perform work/school/household tasks?	☐	☐	☐	☐
22. . . . been able to participate in your usual social activities?	☐	☐	☐	☐

Please indicate how much you agree or disagree . . .	**Strongly Agree**	**Agree**	**Slightly Agree**	**Slightly Disagree**	**Disagree**	**Strongly Disagree**
23. I am able to bounce back when things go wrong.	☐	☐	☐	☐	☐	☐
24. When I have problems I go to people who can help me.	☐	☐	☐	☐	☐	☐
25. I am confident that treatment can help me.	☐	☐	☐	☐	☐	☐
26. *In my sessions…* (*if applicable*) I am making good progress.	☐	☐	☐	☐	☐	☐
I can talk about what's really on my mind.	☐	☐	☐	☐	☐	☐

If you have not completed this form within the last 12 months, please answer the following:

27. How long have you had your current problem ? ☐ 0-1 month ☐ 2-3 months ☐ 4-6 months ☐ Longer
28. Number of times you've been in counseling/therapy before now: ☐ Never ☐ 1 ☐ 2-3 ☐ 4 or more
29. Have you ever been hospitalized for a psychological or emotional problem? ☐ Never ☐ Once ☐ 2 or more times

Woodland Hills/External Providers Fax to (215) 558-5355

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