

TriCounty Addiction Services
How am I Doing?

Name: _____

Date: _____

Many of us experience problems such as those in the list below. Please check (✓) whether you consider each to be: **No Concern, Minor Concern, Moderate Concern, Serious Concern, Crisis Problem**. This checklist will help you zero in on your treatment needs and the goals you hope to achieve. For each issue, if it does not apply to you, please check No Concern.

If you become distressed or very anxious or experience troubling thoughts or feelings when considering any of these concerns in your life, please let the person know who has asked you to do this questionnaire, before you leave the meeting.

	No Concern	Minor Concern	Moderate Concern	Serious Concern	Crisis Problem
My use of Alcohol/Drinking					
My use of Other Substances (drug)					
My use of Prescriptions (medication)					
My Gambling					
Another person's use of Alcohol/Drinking					
Another person's use of Other Drugs or Medications					
Another person's Problem Gambling					
Housing Arrangements/Accommodations					
Finances – Money Matters					
Leisure or Recreation Activities/Time					
Friendships					
Relationships with current or past Partner(s)					
Sexual Relationships					
Family Relationships					
How I look after my children					
Religion or Spirituality					
Eating Disorder					
My Mental Health (please list: _____)					
Another Person's Mental Health					
Weight					
Fear					

	No Concern	Minor Concern	Moderate Concern	Serious Concern	Crisis Problem
Loneliness					
My Eating Habits					
Sleeping Problems					
Smoking					
Coffee, Tea or Soft Drinks with caffeine					
Sexual or Physical Abuse done to me					
Sexual or Physical Abuse I have done to others					
Legal Problems					
Work or School					
Guilt					
Anger					
Thoughts of Suicide					
Physical Health (please list: _____)					
Shame					
My Ability to Communicate					
Assertiveness					
Thoughts of Harming Someone					
Depression					
Anxiety					
Other (please list: _____)					

Now that you have identified the concerns or problems that you experience in your life, please rank the ones that are most important for you, with #1 being Most Important, then #2, then #3,

1. _____
2. _____
3. _____

Please continue

What are your **goals** for change? That is, what problems or concerns might you want to overcome, to learn to accept, to understand, to cope better with, to confront, to be better at, to develop more, to examine, to increase, to decrease, etc. Please try to identify objectives that you can actually achieve.

What **other treatment** or self-help have you had before, or are having now, that has helped you?

What **barriers** or obstacles will get in the way of you achieving the objectives/ goals you have set for yourself?

What **supports** are there in your life which will help you achieve the objectives you have set for yourself?

Thank you for working with us to explore the nature and extent of the difficulties you are facing, the changes you are considering in your life, the obstacles you might encounter, and the supports on which you can call to achieve you goals.

If you have become distressed while completing this form, please let the person know who has asked you to do this questionnaire. Particularly if you think you have a serious or crisis problem with thinking about suicide or harming someone else, please ask to speak to the person leading the orientation before you leave.

If you would like a copy of this form after you have completed it, please request that from the person who asked you to complete it.