

### CLIENT FORM - 1

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Date at start of therapy (if different): \_\_\_\_\_

Have you been treated before for the same difficulties? \_\_\_\_\_

Are you currently being treated for the same difficulties (For example, are you seeing a counsellor, doctor, nurse, or psychiatrist)? \_\_\_\_\_

If you have answered yes to either of the questions above, please describe the other treatment below:

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### DIRECTIONS

On the other side of this page is a list of five areas of life in which people can experience discomfort (behaviours, thoughts, physical sensations, feelings, and relationships). There are also two ways of assessing your experience. One is the strength of the experience; the other is how much you can manage the discomfort.



Please follow carefully the instructions below and ask your assessor for more detail if needed.



Try not to spend too long on your answers. There is no right or wrong answer.

FULL NAME:..... DATE.....

**How strong  
or upsetting  
were your**



Circle one number in each column in the section below according to **how strong or upsetting your experiences were** IN THE PAST 7 DAYS, INCLUDING TODAY

	Not at all or a little	Moderate	Strong but bearable	Sometimes unbearable	Unbearable most of the time
UNWANTED BEHAVIOURS / ACTIONS	0	1	2	3	4
UNPLEASANT THOUGHTS	0	1	2	3	4
UNPLEASANT BODY SENSATIONS	0	1	2	3	4
UNPLEASANT FEELINGS / EMOTIONS	0	1	2	3	4
UNPLEASANT RELATIONS WITH OTHERS	0	1	2	3	4

**How  
manageable  
were your**



Circle one number in each column in the section below according to **how you coped with the above experiences (how manageable were they)** IN THE PAST 7 DAYS, INCLUDING TODAY

	Easily manageable	Moderately manageable	Managed with difficulty	Sometimes unmanageable	Unmanageable most of the time
UNWANTED BEHAVIOURS / ACTIONS	0	1	2	3	4
UNPLEASANT THOUGHTS	0	1	2	3	4
UNPLEASANT BODY SENSATIONS	0	1	2	3	4
UNPLEASANT FEELINGS / EMOTIONS	0	1	2	3	4
UNPLEASANT RELATIONS WITH OTHERS	0	1	2	3	4

### CLIENT FORM - 2

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Date at start of therapy (if different): \_\_\_\_\_

Have you been given another treatment for the same difficulties since you started therapy? \_\_\_\_\_

If yes, please describe the other treatment and the reason for it below:

### DIRECTIONS

On the other side of this page is a list of five areas of life in which people can experience discomfort (behaviours, thoughts, physical sensations, feelings, and relationships). There are also two ways of assessing your experience. One is the strength of the experience; the other is how much you can manage the discomfort.



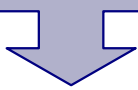
Please follow carefully the instructions below and ask your assessor for more detail if needed.



Try not to spend too long on your answers. There is no right or wrong answer.

FULL NAME:..... DATE.....

**How strong  
or upsetting  
were your**



Circle one number in each column in the section below according to **how strong or upsetting your experiences were** BEFORE YOUR FIRST THERAPY SESSION

	Not at all or a little	Moderate	Strong but bearable	Sometimes unbearable	Unbearable most of the time
UNWANTED BEHAVIOURS / ACTIONS	0	1	2	3	4
UNPLEASANT THOUGHTS	0	1	2	3	4
UNPLEASANT BODY SENSATIONS	0	1	2	3	4
UNPLEASANT FEELINGS / EMOTIONS	0	1	2	3	4
UNPLEASANT RELATIONS WITH OTHERS	0	1	2	3	4

**How  
manageable  
were your**



Circle one number in each column in the section below according to **how you coped with the above experiences (how manageable were they)** BEFORE YOUR FIRST THERAPY SESSION

	Easily manageable	Moderately manageable	Managed with difficulty	Sometimes unmanageable	Unmanageable most of the time
UNWANTED BEHAVIOURS / ACTIONS	0	1	2	3	4
UNPLEASANT THOUGHTS	0	1	2	3	4
UNPLEASANT BODY SENSATIONS	0	1	2	3	4
UNPLEASANT FEELINGS / EMOTIONS	0	1	2	3	4
UNPLEASANT RELATIONS WITH OTHERS	0	1	2	3	4

### CLIENT FORM - 3

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Date at start of therapy: \_\_\_\_\_

Have you been given another treatment for the same difficulties since you started therapy? \_\_\_\_\_

If yes, please describe the other treatment and the reason for it below:

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### DIRECTIONS

This assessment is identical to the one you were given when you started therapy. On the other side of this page is a list of five areas of life in which people can experience discomfort (behaviours, thoughts, physical sensations, feelings, and relationships). There are also two ways of assessing your experience. One is the strength of the experience; the other is how much you can manage the discomfort.



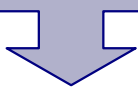
Please follow carefully the instructions below and ask your assessor for more detail if needed.



Try not to spend too long on your answers. There is no right or wrong answer.

FULL NAME:..... DATE.....

**How strong  
or upsetting  
were your**



Circle one number in each column in the section below according to **how strong or upsetting your experiences were** IN THE PAST 7 DAYS, INCLUDING TODAY

	Not at all or a little	Moderate	Strong but bearable	Sometimes unbearable	Unbearable most of the time
UNWANTED BEHAVIOURS / ACTIONS	0	1	2	3	4
UNPLEASANT THOUGHTS	0	1	2	3	4
UNPLEASANT BODY SENSATIONS	0	1	2	3	4
UNPLEASANT FEELINGS / EMOTIONS	0	1	2	3	4
UNPLEASANT RELATIONS WITH OTHERS	0	1	2	3	4

**How  
manageable  
were your**



Circle one number in each column in the section below according to **how you coped with the above experiences (how manageable were they)** IN THE PAST 7 DAYS, INCLUDING TODAY

	Easily manageable	Moderately manageable	Managed with difficulty	Sometimes unmanageable	Unmanageable most of the time
UNWANTED BEHAVIOURS / ACTIONS	0	1	2	3	4
UNPLEASANT THOUGHTS	0	1	2	3	4
UNPLEASANT BODY SENSATIONS	0	1	2	3	4
UNPLEASANT FEELINGS / EMOTIONS	0	1	2	3	4
UNPLEASANT RELATIONS WITH OTHERS	0	1	2	3	4

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Date at start of therapy: \_\_\_\_\_

**DIRECTIONS**

Below is a list of five areas of life in which people can experience improvement (behaviours, thoughts, physical sensations, feelings, and relationships). Please circle one number in each column in the section below according to HOW MUCH IMPROVEMENT you have experienced in each of these five areas.

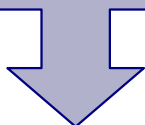


Please ask your assessor if you need more detail.



Try not to spend too long on your answers. There is no right or wrong answer.

How do you  
perceive your  
improvement  
with



	Have worsened	No improvement noted	Small improvements	Clearly visible improvement overall	Significant improvement, goal reached
UNWANTED BEHAVIOURS / ACTIONS	0	1	2	3	4
UNPLEASANT THOUGHTS	0	1	2	3	4
UNPLEASANT BODY SENSATIONS	0	1	2	3	4
UNPLEASANT FEELINGS / EMOTIONS	0	1	2	3	4
UNPLEASANT RELATIONS WITH OTHERS	0	1	2	3	4

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Date at start of therapy: \_\_\_\_\_

**DIRECTIONS**

Below is a list of five areas related to therapy. Please circle one number in each column in the section below according to HOW SATISFIED YOU ARE with each part of the therapy you have had.



Please ask your assessor if you need more detail.



Try not to spend too long on your answers. There is no right or wrong answer.

**How satisfied are you with**



	Not at all satisfied	A little satisfied	Moderately satisfied	Very satisfied	Extremely satisfied
TREATMENT TYPE	0	1	2	3	4
TREATMENT LENGTH	0	1	2	3	4
RELATIONSHIP WITH THERAPIST	0	1	2	3	4
THE SKILLS YOU LEARNED	0	1	2	3	4
COST (IF APPLICABLE)	0	1	2	3	4