Multicultural Counseling Services

Check In Form

Your Name _____ **Date:** _____

Symptoms Rating. *Please circle a number to represent the severity of your symptoms since your last session.*											
Not Depressed	1	2	3	4	5	6	7	8	9	10	**Depressed**
Not Anxious	1	2	3	4	5	6	7	8	9	10	**Anxious**
Not Irritable	1	2	3	4	5	6	7	8	9	10	**Irritable**
High Self Esteem	1	2	3	4	5	6	7	8	9	10	**Low Self Esteem**
Other:	1	2	3	4	5	6	7	8	9	10	

Treatment Goals. *Briefly indicate your goals and progress.*	No progress	A little progress	A lot of progress
Goal 1:			
Goal 2:			
Goal 3:			

Current Medications. *Briefly note your medications and any concerns. If you discontinued your medication, when?*

Agenda Items for Today. *Briefly note the topics you would like to cover in today's session.*
1.
2.
3.