From Open Door Community Health Centers

Behavioral Health Consultation Symptom Progress Checklist

This checklist has been designed to determine the overall effectiveness of the treatment you have received by your Behavioral Health Consultant. Please take a few minutes to read each statement and circle the rating that best matches your answer. Your responses will be compiled with other patients in a report for the Behavioral Health Consultant. The Behavioral Health Consultant can then use the information to help you and other patients. Your answers are confidential, so you do not need to put your name on this form. Thank you for your participation!

1. **Please check the reasons(s) that brought you to see the Behavioral Health Consultant (please mark all that apply):**

❑ Depression	❑ Anxiety	❑ Relationship Issues	❑ Stress Reduction
❑ Smoking	❑ Eating Patterns	❑Weight Control	❑ Work Related Stress
❑ Trauma Recovery	❑ Chronic Pain	❑ Substance Abuse Issues	❑ Parenting Issues
❑ Social Issues	❑ Grief	❑ Health Related Issues	❑ Habit Breaking
❑ Sexual Issues	❑ Phobias	❑ Adjustment Issues	❑ Other_____

2. **Using the scale below, please circle the severity of your symptoms when you first came to visit the Behavioral Health Consultant**

   0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
   mild moderate severe

3. **Please circle the number of visits (approximately) that you have had with the Behavioral Health Consultant.**

   0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

4. **Using the scale below, please circle the severity of the symptoms today**.

   0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
   mild moderate severe

5. **Using the scale below, please circle the level of improvement you think you have achieved through the help of the Behavioral Health Consultant.**

   0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
   no improvement some improvement complete improvement

6. **Have you discontinued Behavioral Health Services? If so, what was the reason?**

❑ Services are being continued	❑ Goals were achieved	❑ Lack of Progress	❑ Relocation or transfer of service	❑ Other _____ _____ _____

7. **Please use this space to make additional comments/suggestions regarding the Behavioral Health Program.**

   _____

   _____