

MCCA
McCracken Counseling and Associates
Experiential Checklist

CLIENTS NAME _____ **DATE** _____

CHECK ALL THAT APPLY

- | | |
|---|---|
| <input type="checkbox"/> ANGER | <input type="checkbox"/> CHRONIC DEPRESSION |
| <input type="checkbox"/> ANXIETY | <input type="checkbox"/> EXTREMELY HAPPY MOOD |
| <input type="checkbox"/> DEPRESSED MOOD | <input type="checkbox"/> FEELINGS OF GUILT |
| <input type="checkbox"/> UNREALISTIC FEAR | <input type="checkbox"/> EASILY AGITATED |
| <input type="checkbox"/> FEELINGS OF GRIEF | <input type="checkbox"/> TENSION |
| <input type="checkbox"/> INSECURITY | <input type="checkbox"/> TROUBLE WITH DECISION MAKING |
| <input type="checkbox"/> FEELING PANIC | <input type="checkbox"/> CONFUSION IN THOUGHT PROCESSES |
| <input type="checkbox"/> LACKING EMOTIONAL EXPRESSION | <input type="checkbox"/> DIFFICULTY WITH MEMORY |
| <input type="checkbox"/> BOREDOM | <input type="checkbox"/> NIGHTMARES |
| <input type="checkbox"/> DELUSIONS | <input type="checkbox"/> POOR JUDGEMENT |
| <input type="checkbox"/> OVERALL NEGATIVE/PESSIMISTIC PERCEPTION | <input type="checkbox"/> CONFLICT IN PERSONAL VALUE SYSTEM |
| <input type="checkbox"/> OBSSIVE THINKING | <input type="checkbox"/> LOUD IN TONE |
| <input type="checkbox"/> SUICIDAL IDEATIONS | <input type="checkbox"/> AVOIDANCE |
| <input type="checkbox"/> HALLUCINATIONS | <input type="checkbox"/> HOMICIDAL |
| <input type="checkbox"/> ALCOHOL/DRUG ABUSE | <input type="checkbox"/> IRRITABLE |
| <input type="checkbox"/> FATIGUE | <input type="checkbox"/> POOR EATING |
| <input type="checkbox"/> IMPULSIVE | <input type="checkbox"/> SLEEP DISTURBANCES |
| <input type="checkbox"/> HYPERACTIVE | <input type="checkbox"/> POOR MANAGER OF MONEY |
| <input type="checkbox"/> LYING | <input type="checkbox"/> CRUELTY TO ANIMALS |
| <input type="checkbox"/> GAINING/LOSING SUBSTANTIAL WEIGHT | <input type="checkbox"/> COMPULSIVE BEHAVIOR |
| <input type="checkbox"/> SELF-DESTRUCTIVE | <input type="checkbox"/> DIFFICULTY COMMUNICATING WITH OTHERS |
| <input type="checkbox"/> TALKING EXCESSIVELY | <input type="checkbox"/> FAMILY CONFLICT |
| <input type="checkbox"/> DESIRE TO RUNAWAY | <input type="checkbox"/> LONELINESS |
| <input type="checkbox"/> FIRESETTING | <input type="checkbox"/> MARITAL CONFLICT |
| <input type="checkbox"/> ATTENTION-SEEKING BEHAVIOR | <input type="checkbox"/> LACKING SELF-CONFIDENCE |
| <input type="checkbox"/> DEPENDENCY ON RELATIONSHIP FOR PERSONAL SATISFACTION | <input type="checkbox"/> INABILITY TO WORK |
| <input type="checkbox"/> RELATIONSHIP ISSUES | <input type="checkbox"/> LACK OF SOCIAL OUTLETS |
| <input type="checkbox"/> MANIPULATIVE BEHAVIOR | <input type="checkbox"/> RETIRED |
| <input type="checkbox"/> WITHDRAWN | <input type="checkbox"/> SERIOUS MEDICAL ISSUES |
| <input type="checkbox"/> SELF-CENTERED | |
| <input type="checkbox"/> CONFLICTS WITH EMPLOYER/EMPLOYEES | |
| <input type="checkbox"/> POOR WORK/SCHOOL PERFORMANCE | |
| <input type="checkbox"/> LACK OF EMOTIONAL SUPPORT | |
| <input type="checkbox"/> LEGAL DIFFICULTIES | |
| <input type="checkbox"/> RECENTLY LOST JOB | |
| <input type="checkbox"/> EXPERIENCING RECENT LOSS OF LOVED ONE | |