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Symptoms of Present Problem

How long have you had the current problem?___________________________________

How well have you been getting along emotionally and psychologically?

Poorly_____ Fairly poorly_____ So-so_____ Fairly well_____ Quite well_______

Very well________

During the past two weeks, how much have you had to cut down on the amount of time you spent on work or other activities as a result of any emotional problems?

Not at all___________ Cut down a little_________

Cut down a lot___________

Are you taking medication for a psychological problem? Yes______

No_______

If yes, name of medication and dosage____

In the PAST WEEK, how often have you had thoughts of harming yourself or someone else?

Never_______ Sometimes________ Often_________

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For the following symptoms please check if you are experiencing any, and to what degree, by indicating one of the following:

0=never 1=very little 2=sometimes 3=often 4=all or almost all the time:

Trouble sleeping (too much, too little) ______________

Trouble falling asleep or staying asleep_______________

Average number of hours of sleep/night______________

Eating Issues (too little, too much)_________________________

Significant Weight Loss or Gain_______________________________

Feeling sad, down, or depressed_________

Feeling hopeless about the future________

Feeling helpless_________

Tearfulness ________

Decreased energy_________

Loss of interest in activities_______

Memory problems________

Difficulty planning ahead___________

Angry outbursts_______

Feeling less pleasure from things you used to enjoy____________

Decreased interest in things__________

Feeling unmotivated__________

Mood changes_____________

Severe mood swings (highs and lows)____________

Increased irritability____________

Decrease in sexual functioning and or interest____________

Nervousness____________

Anxiety________________

Shakiness___________

Racing Thoughts___________

Pounding Heart___________

Trouble concentrating_____________

Trouble breathing___________

Spending Sprees__________

Unsafe or reckless behaviors____________

Sweating______

Nightmares or night terrors___________

Flashbacks of traumatic event____________

Waking up with a start__________

Avoidance or certain places_________

Withdrawal from social activities________

Impulse control issues (difficulty controlling physical behavior or hyperactive)____________

Stealing_____

Lying______

Truancy________

Fire setting_____

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Hearing voices_______

Seeing things that are not there______________________________

Feeling guilty about your alcohol or drug use or feel that you should cut back____

Feel your health, work, or home life was affected by your drinking or drug use____

Difficulty at home____

Difficulty socially____

Difficulty at work or school_______________________________________

How much do you agree with the following?

I feel good about myself____

I can deal with my problems____

I have friends or family that I can count on for help________________________________

I can manage my day to day life____

I am able to perform personal, household, work or school tasks____