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PROBLEM INVENTORY- Please check the following problems you may be CURRENTLY experiencing.

Name: **DOB:**

Date Of Service:

- ☐Marital relationship problems
- ☐Problems on the job
- ☐Losing someone or something close to me (person, job, pet, moving, etc.)
- ☐Problems with my children
- ☐Physical abuse
- ☐Sexual abuse
- ☐Current problems from past sexual abuse
- ☐Alcohol abuse
- ☐Drug abuse
- ☐Feeling guilty about past misdeeds
- ☐Feeling that I am no good
- ☐Feeling the need to get more sleep
- ☐Losing pleasure in my daily activities
- ☐Often feeling restless or irritable
- ☐Thinking about dying or killing myself
- ☐Trouble concentrating
- ☐Feeling sad or "down in the dumps"
- ☐Needing more sleep than usual
- ☐Needing less sleep than usual
- ☐Specific fear of a thing or place
- ☐Attacks of fearfulness where I feel I need to run
- ☐Heart palpitations
- ☐Chest pains or discomfort
- ☐Feeling dizzy or unsteady
- ☐Tingling in hands or feet
- ☐Sweating when anxious
- ☐Trouble breathing
- ☐Trembling or shaking
- ☐Fears of dying or going crazy
- ☐Feeling the urge to avoid certain places or objects
- ☐Fear of germs
- ☐Feeling troubled by repetitive thoughts
- ☐Feeling anxious and nervous
- ☐Worrying about things over and over
- ☐Pulling my hair out
- ☐Trouble making myself slow down or talk less
- ☐Staying up all night with energy the next day
- ☐Checking, counting things
- ☐People following me, out to hurt me, or talking about me
- ☐People reading my thoughts
- ☐Hearing voices
- ☐Seeing or hearing things no one else can see or hear
- ☐Thoughts being put into my head, controlling me, making me do things
- ☐Special messages to me from TV or radio
- ☐Feeling emotionally "numb"
- ☐Recurring nightmares
- ☐Frequently feeling startled
- ☐Being troubled by painful memories
- ☐Parts of my body not functioning well
- ☐Feeling aches and pains all over my body
- ☐Fear of crowds or public places
- ☐Spending sprees
- ☐Problems with my memory or ☐knowing where or who I am
- ☐Getting lost or confused
- ☐Having trouble remembering my past
- ☐Finding things I don't remember having
- ☐Feeling that I've lost time
- ☐Urges to do something harmful to myself or others
- ☐Urges to set fires
- ☐Difficulty controlling my temper
- ☐Feeling anger or resentment
- ☐Taking laxatives to control my weight
- ☐Vomiting to control my calorie intake
- ☐Exercising frequently and vigorously
- ☐Fasting in order to control my weight
- ☐Feeling helpless about my eating habits
- ☐Weight loss or gain of 20lbs or more
- ☐Often feeling sickly
- ☐Fear of having or getting a disease

Any other problems not mentioned above:

Current Symptoms Checklist

☐Depressed mood	☐Excessive guilt	☐Increased libido	☐Anxiety attacks
☐Unable to enjoy activities	☐Fatigue	☐Decreased need for sleep	☐Avoidance
☐Sleep pattern disturbances	☐Decreased libido	☐Excessive energy	☐Hallucinations (visual/auditory)
☐Loss of interest in activities	☐Racing thoughts	☐Increased irritability	☐Suspiciousness
☐Forgetfulness	☐Impulsivity	☐Crying spells	☐Legal problems
☐Change in appetite	☐Increase risky behavior	☐Excessive worry	☐other

Have you ever had feelings or thoughts that you do not want to live? Yes ☐ No ☐	When was the last time you had thoughts of dying?	On a scale of 1 to 10, (10 being the strongest) how strong is your desire to kill yourself currently?
If Yes: How often do you have these thoughts? all the time ☐daily ☐ weekly ☐ monthly ☐ If Yes: Do you currently want to live? Yes ☐ No ☐	Have you ever thought about how you would kill yourself?	Do you have a planned time to harm yourself?
Have you ever tried to harm or kill yourself before? Yes ☐No ☐	Have you ever been hospitalized for psychiatric reasons? If yes: When? Where:	

PSYCHOTHERAPY NOTES TO BE EXCLUDED FROM INCLUSION WITH MEDICAL RECORD PER SECTION 45 CFR 164.201 FL