

Carpenter House, Inc.
Kathlyn C. White, MA, LMHC, LMFT, QS



4400 Highway 20 East Suite 306

Niceville, FL 32578-5383

Phone: 850-897-7810 Fax: 850-897-0032

www.carpenterhouse.net

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

Name: _____

DOB: _____

Date Of Service: _____

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

Any other problems not mentioned above: _____

Current Symptoms Checklist

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

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

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