Carpenter House, Inc.
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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
Any other problems not mentioned above:

☐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

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 ☐ 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 ☐	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?
	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

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