Carpenter House, Inc.
4400 Highway 20 East Suite 306
Niceville, FL 32578-5383
Phone: 850-897-7810 Fax: 850-897-0032

Problem Inventory – CURRENT ISSUES

Name: _____ DOB: _____

Reason for seeking treatment: _____

The information that you provide will help us better know how to serve you and will be kept strictly confidential.

(check all the apply)

☐ Marital relationship problems	☐ Checking and counting things over and over
☐ Physical abuse **(circle)** Current / Past	☐ Fear of germs
☐ Problems on the job	☐ Codependency
☐ Losing someone/something close to me (person, job, pet, friends, etc.)	☐ People following me, out to hurt me, or talking about me
☐ Problems with my children	☐ People reading my thoughts
☐ Sexual abuse	☐ Hearing voices
☐ Current problems from past sexual abuse	☐ Thoughts being put in my head, controlling me, making me do things
☐ Alcohol abuse	☐ Special messages to me from TV or radio
☐ Drug abuse	☐ Feeling emotionally "numb"
☐ Feeling guilty about past misdeeds	☐ Reoccurring nightmares
☐ Feeling that I am no good	☐ Frequently feeling startled
☐ Feeling the need to get more sleep	☐ Being troubled by painful memories
☐ Losing pleasure in my daily activities	☐ Chronic pain
☐ Often feeling restless or irritable	☐ Feeling aches and pains all over my body
☐ Trouble keeping my mind on a task	☐ Fear of crowds or public places
☐ Feeling sad or "down in the dumps"	☐ Fear of having or getting a disease
☐ Preoccupied with sexual thoughts or urges	☐ Problems with my memory
☐ Specific Fear of a thing or place	☐ Getting lost or confused
☐ Attacks of fearfulness where I feel I need to run	☐ Having trouble remembering my past
☐ Heart palpitations	☐ Finding something I didn't remember having
☐ Chest pains or discomfort	☐ Feeling like I've lost time
☐ Feeling dizzy or unsteady	☐ Urges to do something harmful to myself or others
☐ Tingling in hands or feet	☐ Urges to set fire
☐ Sweating when anxious	☐ Difficulty controlling my temper
☐ Trouble breathing or catching your breath	☐ Taking laxatives to control my weight
☐ Trembling or shaking	☐ Vomiting to control calorie intake
☐ Fears of dying or going crazy	☐ Exercising frequently and vigorously
☐ Feeling the urge to avoid certain places or objects	☐ Fasting in order to control my weight
☐ Feeling troubled by repetitive thoughts	☐ Feeling helpless about my eating habits
☐ Feeling anxious and nervous	☐ Extreme changes in my weight **(+20lbs lost or gained)**
☐ Worrying about things over and over	☐ Often feeling sick
☐ Trouble slowing down or talking less	☐ Fear of having or getting a disease
☐ Staying up all night with energy the next day	☐

Any other problems not mentioned above: _____

_____

_____

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Describe your **current** symptoms or behaviors for the **past two weeks** by Indicating how frequent by "Never", "Several days", "More than half" of the days, or "Almost every day".

	Never	Several days	More than half the time	Almost Everyday
Anxiety Attacks	O	O	O	O
Change in Appetite	O	O	O	O
Concentration/Forgetfulness	O	O	O	O
Crying Spells	O	O	O	O
Anger/Rage	O	O	O	O
Racing Thoughts	O	O	O	O
Hallucinations	O	O	O	O
Hopeless	O	O	O	O
Impulsivity	O	O	O	O
Excessive Energy	O	O	O	O
Sleeping too Much	O	O	O	O
Sleeping too Little	O	O	O	O
Nightmares	O	O	O	O
Irritability	O	O	O	O
Fatigue	O	O	O	O
Fearful	O	O	O	O
Fighting	O	O	O	O
Stress/Tension	O	O	O	O
Little interest in Doing Things	O	O	O	O
Obsessions	O	O	O	O
Suspiciousness	O	O	O	O
Excessive Worry	O	O	O	O
Other:	O	O	O	O

Who lives with you?

Name	Age	Relationship

Describe the quality of your personal support system. Who do you rely on for social support or to be there for you when you need help?

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Suicide Risk Assessment:

Have you ever been hospitalized for psychiatric reasons? ☐ YES ☐ NO

If Yes: When? Where? _____

Have you ever tried to harm or kill yourself before? ☐ YES ☐ NO

Have you ever had the feeling or thoughts that you do not want to live? ☐ YES ☐ NO

If Yes: How often do you have these thoughts? **If No, skip to Family History.**
☐ Several days of the week ☐ More than half the days in the week ☐ Almost everyday

When was the last time you thought 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? ☐ YES ☐ NO

Is there a planned time for this? ☐ YES ☐ NO

Family History

Have you, or anyone in your family, ever been diagnosed as having schizophrenia? ☐ YES ☐ NO

Have you, or anyone in your family, ever been diagnosed as being depressed? ☐ YES ☐ NO

Have you, or anyone in your family, ever been diagnosed as having a drug or alcohol problem? ☐ YES ☐ NO

Have you, or anyone in your family, ever been diagnosed as being manic/depressive or bipolar? ☐ YES ☐ NO

Have you, or anyone in your family, ever been diagnosed as having a form of autism? ☐ YES ☐ NO

Have you, or anyone in your family, ever been sexually abused or witnessed a traumatic event? ☐ YES ☐ NO