Please fill out all pages completely

Client Information Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name (First, MI, Last): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender: Male \_\_\_ Female \_\_\_ Marital Status \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If the patient is under the age of 18, who is the legal guardian (name/relationship): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Which ways may we contact you? \_\_\_ Home phone \_\_\_ Cell phone \_\_\_ Work phone

 \_\_\_ Mail \_\_\_ Email \_\_\_ Text message

**Emergency Contact:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City, State, Zip Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alternate phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City, State, Zip Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alternate phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**List persons living in your home**

Name Relationship Age Birthdate

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

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How did you hear about Carolinas Counseling Center?

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe the problem or concern that you are seeking help for today:

# Medical, Mental Health, and Nutritional Information

Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_

**Most recent examinations**:

 Date Results

Physical examination

Dental examination

Vision examination

Hearing examination

**Allergies related to any medications, food, or anything else**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**List any current medications that you are taking:**

**Current medications**: Dose Dates Purpose

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently experiencing any **acute or chronic pain?**

 Location of the Pain Severity: (0-10) How long have you been experiencing this pain?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**For children under age 18:** Please check if your child currently or recently experienced any of the following:

 Abortion Hayfever Pneumonia

 Asthma Heart trouble Polio

 Blackouts Hepatitis Pregnancy

 Bronchitis Hives Rheumatic Fever

 Cerebral Palsy Influenza Scarlet Fever

 Chicken Pox Lead poisoning Seizures

 Congenital problems Measles Severe colds

 Croup Meningitis Severe head injury

 Dental Problems Miscarriage Sexually transmitted disease

 Diabetes Multiple sclerosis Thyroid disorders

 Dizziness Mumps Vision problems

 Ear aches Muscular Dystrophy Wearing glasses

 Ear infections Nose bleeds \_\_\_\_\_ Weight + or – (past 3 months)

 Eczema Other skin rashes Whooping cough

 Encephalitis Paralysis \_\_\_\_\_ Other (Please describe below)

 Fevers Pleurisy

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**For Adults 18 or older:** Please check if you are currently or have recently experienced any of the following:

 AIDS/HIV Dizziness Nose bleeds

 Alcoholism Drug abuse Pneumonia

 Abdominal pain Epilepsy Rheumatic Fever

 Abortion Ear infections Sexually transmitted diseases

 Allergies Eating problems Sleeping disorders

 Anemia Fainting Sore throat

 Appendicitis Fatigue Scarlet Fever

 Arthritis Headaches Sinusitis

 Asthma Hearing problems Smallpox

 Bronchitis Heart problems Stroke

 Bed wetting Hepatitis Sexual problems

 Cancer High blood pressure Tonsillitis

 Chest pain Kidney problems Tuberculosis

 Chronic pain Measles Toothache

 Colds/Coughs Mononucleosis Thyroid problems

 Constipation Mumps Vision problems

 Chicken Pox Menstrual pain Ulcers

 Dental problems Miscarriages Weight + or – (past 3 months)

 Diabetes Neurological disorders \_\_\_\_\_ Whopping cough

 Diarrhea Nausea/Vomiting \_\_\_\_\_Other (Please describe below)

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Social and Spiritual Involvement and Activities

Are you involved in any organized social or athletic groups or clubs? If so, please tell us which ones:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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About how many times per month do you participate in social or athletic groups or activities? \_\_\_\_\_\_\_\_

How many close family members are involved in your life? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many good friends are involved in your life? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Are you involved in a church, religious group, or spiritual movement? \_\_\_\_ Yes \_\_\_\_ No

If yes, which one is it? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How important is it to you? \_\_\_\_ Very important \_\_\_\_ Somewhat \_\_\_\_ A little bit \_\_\_\_ Not at all

How many times per month do you do each of the following:

\_\_\_\_ Pray \_\_\_\_ Read scriptures \_\_\_\_ Sing religious songs \_\_\_\_ Meditate

\_\_\_\_ Talk to family or friends about your beliefs \_\_\_\_ Use your faith to cope with problems

\_\_\_\_ Attend worship services \_\_\_\_ Attend church activities other than worship

**How much of the following substances do you use each week:**

 Alcohol \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Coffee \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Tobacco \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tea \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Energy drinks \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Soft drinks \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Marijuana \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pain medication \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you believe that you currently have a problem with using too much of any of these substances**, or that you have had a problem with using them too much in the past? Please explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Have any of your relatives had**:

 \_\_\_\_ Problems with Alcohol or Drugs \_\_\_\_ Mental, emotional or “nerve” problems

**Estimate how many hours per week you spend online or on a cell phone, doing the following:**

Facebook/Social Networking \_\_\_\_\_    Watching videos \_\_\_\_\_\_     Gaming \_\_\_\_\_\_

Browsing websites \_\_\_\_\_    Texting   \_\_\_\_\_\_       TV or movies   \_\_\_\_\_\_

At work \_\_\_\_\_\_   At school \_\_\_\_\_\_ At home \_\_\_\_\_\_

 Do you feel your technology use is balanced and healthy, or are you concerned about how much you use it?

Please explain:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Previous Mental Health Treatment**:

Have you had previous counseling or mental health treatment? \_\_\_\_ Yes \_\_\_\_ No

If yes, please give the details of your treatment below:

Name of treatment provider Location Dates Reasons for treatment

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you ever been hospitalized for emotional or psychiatric problems? \_\_\_\_Yes \_\_\_\_No

If yes, please give the details of your hospitalization below:

Hospital Name Location Dates Diagnoses/Condition

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Painful experiences**

\_\_\_ No \_\_\_ Yes – Have you ever been bullied, verbally harassed or intimidated by family members, friends, neighbors, fellow students or co-workers?

\_\_\_ No \_\_\_ Yes – Have you ever bullied, harassed, or intimidated another person?

\_\_\_ No \_\_\_ Yes – Have you ever experienced physical abuse or violent behavior from a parent, guardian, teacher, older sibling, or another person who was responsible for supervising you or taking care of you?

\_\_\_ No \_\_\_ Yes – have you ever been physically abusive or violent toward someone else?

\_\_\_ No \_\_\_ Yes – Have you ever experienced unwanted sexual attention, been sexually molested or abused, or experienced a sexual assault?

\_\_\_ No \_\_\_ Yes – Have you ever tried to pressure or force sexual attention on someone else?

\_\_\_ No \_\_\_ Yes – Have you ever experienced an event in which you were afraid of being seriously hurt or killed, or witnessed someone else going through such a terrifying event?

\_\_\_ No \_\_\_ Yes – Have you had a serious disruption in your family, such as marital separation or divorce, involvement foster care, or the death of a parent, spouse, or a child?

Listed below are a number of categories in which people often have some difficulties. **Please check any symptoms that you have had in the past 2-4 weeks.** If something has been a problem in the past, but not recently, please put a **P** next to it instead of a check.

Physical Functions

\_\_\_\_ Difficulty sleeping

\_\_\_\_ Sleeping too much

\_\_\_\_ Loss of appetite

\_\_\_\_ Eating too much

\_\_\_\_ Gaining too much weight

\_\_\_\_ Losing too much weight

\_\_\_\_ Poor bladder control

\_\_\_\_ Poor bowel control

\_\_\_\_ Seizures or convulsions

\_\_\_\_ Speech (stuttering or stammering)

\_\_\_\_ Sexual problems

\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your behavior

\_\_\_\_ Difficulty with daily routine

\_\_\_\_ Letting others take advantage of you

\_\_\_\_ Restlessness, difficulty sitting still

\_\_\_\_ Too much energy, can’t stay still

\_\_\_\_ Acting without thinking

\_\_\_\_ Repeating certain acts again and again

\_\_\_\_ Crying a lot, or too much

\_\_\_\_ Using alcohol to cope with problems

\_\_\_\_ Using drugs to cope with problems

\_\_\_\_ Hurting yourself

\_\_\_\_ Trying to kill yourself

\_\_\_\_ Hurting animals

\_\_\_\_ Damaging other people’s property

\_\_\_\_ Arguing with others frequently

\_\_\_\_ Physically attacking or hurting others

\_\_\_\_ Lying

\_\_\_\_ Stealing

\_\_\_\_ Setting fires

\_\_\_\_ Suspicious of others

\_\_\_\_ Withdrawing from others

\_\_\_\_ Hostile or frequently angry toward others

\_\_\_\_ Not wanting to cooperate with others

\_\_\_\_ Depending on others to make decisions

\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your experience at work/school

\_\_\_\_General performance

\_\_\_\_ General satisfaction

\_\_\_\_ Lateness

\_\_\_\_ Absenteeism/Truancy

\_\_\_\_ Negative feelings about work/school

\_\_\_\_ Relating to supervisors/teachers

\_\_\_\_ Relating to co-workers/fellow students

\_\_\_\_ Relating to supervisees

\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your feelings and moods

\_\_\_\_ Sadness or depression

\_\_\_\_ Euphoria (feeling high)

\_\_\_\_ Irritability or feeling angry

\_\_\_\_ Sudden mood changes for no apparent reason

\_\_\_\_ Anxiety (nervousness)

\_\_\_\_ Panic attacks

\_\_\_\_ Lack of energy

\_\_\_\_ Frequent fears or worrying

\_\_\_\_ Not liking yourself

\_\_\_\_ Feeling guilty or worthless

\_\_\_\_ Loss of interest or pleasure in most things

\_\_\_\_ Feeling hopeless

\_\_\_\_ Thoughts of dying or hurting yourself

\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Inner thoughts and ideas

\_\_\_\_ Unwanted thoughts again and again

\_\_\_\_ Racing thoughts

\_\_\_\_ Feeling confused, or difficulty thinking clearly

\_\_\_\_ Frequent worrying

\_\_\_\_ Difficulty concentrating or remembering things

\_\_\_\_ Believing others are better than you

\_\_\_\_ Believing you are better than others

\_\_\_\_ Feeling very suspicious of others

\_\_\_\_ Hearing things that others cannot hear

\_\_\_\_ Seeing things that others cannot see

\_\_\_\_ Believing things that others think are strange

\_\_\_\_ Feeling distant or out of touch with yourself

\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other problems

\_\_\_\_ Marriage or relationship problems

\_\_\_\_ Parent/child conflict

\_\_\_\_ Loss or Death of a loved one

\_\_\_\_ Spiritual or religious concerns

\_\_\_\_ Financial problems

\_\_\_\_ Legal problems