NAME_____DATE_____

PLEASE READ AND MARK AN "X" IN ONE OF THE COLUMNS FOR EACH ITEM. DECIDE WHICH ITEM DESCRIBES YOU BEST.

SYMPTOMS CONCERNS

	within the last week	within the last 6 months	infrequently or never
Difficulty sleeping	—	—	—
Poor physical condition	—	—	—
Anxious and tense	—	—	—
Unreasonable fears	—	—	—
Disturbing thoughts	—	—	—
Unable to sit still	—	—	—
Sad, discouraged	—	—	—
Feel misunderstood by others	—	—	—
Family problems	—	—	—
Poor social life	—	—	—
Quick to anger	—	—	—
Physical violence	—	—	—
Drinking more than usual	—	—	—
Difficulty remembering	—	—	—
Can't get things done	—	—	—
Sexual conflicts	—	—	—
Nightmares	—	—	—
Religious conflicts	—	—	—
Overwhelming guilt feelings	—	—	—
Substance abuse problems	—	—	—
Feel like killing self	—	—	—
In trouble with law	—	—	—
Experiencing strange things	—	—	—
Seeing visions	—	—	—
Hearing things that others don't	—	—	—
Headaches or stomach aches	—	—	—
Heavy use of medications	—	—	—
Change in eating habits	—	—	—