Name: _____ Date:_____

Initial Problem Checklist

Please indicate which of the listed symptoms you are experiencing at the present time.

0 – NOT AT ALL 1 – MILD 2 – MODERATE 3 – SERIOUS 4 – SEVERE

0 1 2 3 4 Feel sad
0 1 2 3 4 Cry easily
0 1 2 3 4 Feel hopeless
0 1 2 3 4 Feel guilty
0 1 2 3 4 Feel irritable
0 1 2 3 4 Feel anxious
0 1 2 3 4 Feel worthless
0 1 2 3 4 Think about suicide
0 1 2 3 4 Past suicide attempts
0 1 2 3 4 Not able to have fun
0 1 2 3 4 Lost interest in usual pleasures
0 1 2 3 4 Unmotivated to complete tasks
0 1 2 3 4 Loss of interest in sex
0 1 2 3 4 Sexual performance problems
0 1 2 3 4 Confusion/"fuzzy" thinking
0 1 2 3 4 Loss of energy/fatigue
0 1 2 3 4 Body feels slowed down
0 1 2 3 4 Thoughts feel slowed down
0 1 2 3 4 Body feels sped up
0 1 2 3 4 Racing thoughts
0 1 2 3 4 Unhappy with weight
0 1 2 3 4 Recent weight gain or loss
0 1 2 3 4 No appetite
0 1 2 3 4 Binge eating
0 1 2 3 4 Intentional vomiting
0 1 2 3 4 Trouble falling asleep
0 1 2 3 4 Sleeping too much
0 1 2 3 4 Trouble staying asleep
0 1 2 3 4 Waking up too early
0 1 2 3 4 Nightmares
0 1 2 3 4 Problems concentrating
0 1 2 3 4 Memory problems
0 1 2 3 4 Indecisiveness
0 1 2 3 4 Withdrawl from others

0 1 2 3 4 Episodes of panic
0 1 2 3 4 Fear of being in public
0 1 2 3 4 Phobias
0 1 2 3 4 Fear of weight gain
0 1 2 3 4 Difficulty making friends
0 1 2 3 4 Loneliness
0 1 2 3 4 Unwanted distressing thoughts
0 1 2 3 4 Repetitive behaviors/nervous habits
0 1 2 3 4 Thoughts or feelings about traumatic events
0 1 2 3 4 Constant worry
0 1 2 3 4 Anxious, on edge
0 1 2 3 4 Bowel disturbances
0 1 2 3 4 Chronic pain
0 1 2 3 4 Worry about health
0 1 2 3 4 Medical problems
0 1 2 3 4 Hear voices
0 1 2 3 4 Suspicious / paranoid thoughts
0 1 2 3 4 See things that are not there
0 1 2 3 4 Strange thoughts
0 1 2 3 4 Anger/rage
0 1 2 3 4 Thoughts about hurting someone
0 1 2 3 4 Poor impulse control
0 1 2 3 4 Work problems
0 1 2 3 4 Relationship problems
0 1 2 3 4 Problems with food
0 1 2 3 4 Problems with money
0 1 2 3 4 Problems at home
0 1 2 3 4 Legal problems
0 1 2 3 4 My use of alcohol, medications, coffee, tobacco has increased
0 1 2 3 4 Use of drugs

What do you see as your strengths? _____
_____

What do you see as your weaknesses? _____
_____

What are your goals for treatment? _____
_____