

PRESENTING PROBLEMS:

NAME: _____

DATE: _____

Check Symptoms that apply

- | | |
|---|---|
| <input type="checkbox"/> Anger | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Lack of energy |
| <input type="checkbox"/> Compulsive behavior | <input type="checkbox"/> Loss of interest |
| <input type="checkbox"/> Confusion | <input type="checkbox"/> Memory loss |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Mood swings |
| <input type="checkbox"/> Excessive use of alcohol or other drugs | <input type="checkbox"/> Nausea/vomiting |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Self critical |
| <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Impulses to hurt self or others (circle which) | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Disorientation (moments of not knowing where you are) | <input type="checkbox"/> Suicidal thoughts |
| <input type="checkbox"/> Visual or auditory hallucinations (seeing or hearing things) | <input type="checkbox"/> Homicidal thoughts |
| <input type="checkbox"/> Sleep difficulties | <input type="checkbox"/> Trouble thinking |
| <input type="checkbox"/> Suspiciousness | <input type="checkbox"/> Medical Conditions (list) |
| <input type="checkbox"/> Obsessive preoccupations or repeated thoughts | _____ |
| <input type="checkbox"/> Weight gain or loss in last year. (circle which) How much? | _____ |

Couple Relationship

- | | |
|--|--|
| <input type="checkbox"/> No couple relationship, which is _____ or is not a problem _____. | |
| <input type="checkbox"/> Tension | |
| <input type="checkbox"/> Emotional distance | <input type="checkbox"/> Argument |
| <input type="checkbox"/> Communication problems | <input type="checkbox"/> Sexual difficulties |
| <input type="checkbox"/> Stresses from health problems | <input type="checkbox"/> Alcohol or other addictions |
| | _____ what person? |

Children: Names/Ages _____

- | | |
|---|-------|
| <input type="checkbox"/> Angry interactions | |
| <input type="checkbox"/> Tension | |
| <input type="checkbox"/> Children exhibiting _____ emotional problems _____ behavior problems | |
| <input type="checkbox"/> Problems between siblings | |
| <input type="checkbox"/> Health problems | _____ |
| <input type="checkbox"/> No children, which is _____ or is not _____ a problem | |

Extended Family:

- | | |
|--|--|
| <input type="checkbox"/> Recent losses | <input type="checkbox"/> Ongoing difficult interactions with _____ |
|--|--|

Work or School:

- | | |
|---|---|
| <input type="checkbox"/> Upsetting interactions | <input type="checkbox"/> Financial Insecurity |
|---|---|

Community-related:

- | | |
|---|--|
| <input type="checkbox"/> Insufficient friendships | <input type="checkbox"/> Tension in friendship relationships |
| <input type="checkbox"/> Overextended in friendships or in community role | |

Other Problems:

