

Listed below are a number of categories in which people commonly find some difficulties. To help us in getting to know you, please indicate how you are affected by each by circling the appropriate number. Please circle one number for each item.

Not a problem	Slight problem	Moderate problem	Serious problem	Severe problem
1	2	3	4	5

<u>I. PHYSICAL</u>		<u>III. BEHAVIOR</u>			
Sleep Pattern	1 2 3 4 5	Difficulty with daily routine	1 2 3 4 5	Anxiety (nervousness)	1 2 3 4 5
Eating Pattern	1 2 3 4 5	Others taking advantage of you	1 2 3 4 5	Lack of energy	1 2 3 4 5
Bladder Control	1 2 3 4 5	Hyperactivity (Can't sit still)	1 2 3 4 5	Feeling angry	1 2 3 4 5
Bowel Control	1 2 3 4 5	Repeating certain act over and over again	1 2 3 4 5	Not liking yourself	1 2 3 4 5
Seizures or Convulsions	1 2 3 4 5	Physically abusing others	1 2 3 4 5	Not liking others	1 2 3 4 5
Speech (stuttering or stammering)	1 2 3 4 5	Using alcohol to cope	1 2 3 4 5	Other _____	1 2 3 4 5
Weight Problem	1 2 3 4 5	Using drugs to cope	1 2 3 4 5		
Exercise	1 2 3 4 5	Lying	1 2 3 4 5	<u>V. THOUGHTS / IDEAS</u>	
Other _____	1 2 3 4 5	Stealing	1 2 3 4 5	Thoughts of hurting yourself	1 2 3 4 5
		Socially withdrawn	1 2 3 4 5	Repeating unwanted thoughts	1 2 3 4 5
<u>II. WORK/SCHOOL</u>		Dependency (relying on others to make decisions for you and take care of you)	1 2 3 4 5	Worries about your health	1 2 3 4 5
General Performance	1 2 3 4 5	Suspiciousness (question other's motives)	1 2 3 4 5	Believing you are inferior to others	1 2 3 4 5
General Satisfaction	1 2 3 4 5	Hostility towards others	1 2 3 4 5	Believing you are better than others	1 2 3 4 5
Lateness	1 2 3 4 5	Others _____	1 2 3 4 5	Seeing things without apparent cause	1 2 3 4 5
Absenteeism	1 2 3 4 5			Hearing things without apparent cause	1 2 3 4 5
Negative feelings about work or school	1 2 3 4 5	<u>IV. FEELINGS AND MOODS</u>		Experiencing confusion	1 2 3 4 5
Relating to supervisors/teachers	1 2 3 4 5	Depression (sadness)	1 2 3 4 5	Memory loss	1 2 3 4 5
Relating to peers	1 2 3 4 5	Euphoria (feeling "high")	1 2 3 4 5	Others _____	1 2 3 4 5
Others _____	1 2 3 4 5	Sudden changes in moods	1 2 3 4 5		

Please indicate the amounts of the following substances you use on a daily basis:

Alcohol ____ Tea ____ Coffee ____ Drugs ____ Tobacco ____ Other _____

Please indicate any current health problems:

- | | | | |
|--|---|---|--------------------------------------|
| <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Eye problems | <input type="checkbox"/> Loss of sex interest | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Backache | <input type="checkbox"/> Gastro-intestinal problems | <input type="checkbox"/> Palpitations | _____ |
| <input type="checkbox"/> Change in menstrual cycle | <input type="checkbox"/> Headache | <input type="checkbox"/> Muscles/Joint pain | _____ |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Shortness of breath | _____ |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Ulcers | _____ |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Vomiting | |