

Valley Counseling Associates, Inc.
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Here is a list of complaints that people sometimes have. Read each one carefully and select the one that best describes HOW MUCH DISCOMFORT THAT PROBLEM HAS CAUSED YOU IN THE PAST MONTH, INCLUDING TODAY. Do not skip any item.

0=Not at all 1=A little bit 2=Moderately 3=Quite a bit 4=Extremely

Nervousness or shakiness inside	0 1 2 3 4
Faintness or dizziness	0 1 2 3 4
The idea that someone else can control your thoughts	0 1 2 3 4
Trouble remembering things	0 1 2 3 4
Difficulty making decisions	0 1 2 3 4
Feeling easily annoyed or irritated	0 1 2 3 4
Pain in heart or chest	0 1 2 3 4
Feeling afraid of open spaces	0 1 2 3 4
Thoughts of ending your life	0 1 2 3 4
Feeling that most people cannot be trusted	0 1 2 3 4
Poor appetite	0 1 2 3 4
Suddenly scared for no reason	0 1 2 3 4
Temper outbursts you could not control	0 1 2 3 4
Feeling lonely even when you are with people	0 1 2 3 4
Feeling blocked in getting things done	0 1 2 3 4
Feeling lonely	0 1 2 3 4
Feeling blue	0 1 2 3 4
Feeling no interest in things	0 1 2 3 4
Feeling fearful	0 1 2 3 4

Your feeling being easily hurt	0 1 2 3 4
Feeling that people are unfriendly or dislike you	0 1 2 3 4
Feeling inferior to others	0 1 2 3 4
Nausea or upset stomach	0 1 2 3 4
Feeling that you are watched or talked about by others	0 1 2 3 4
Trouble falling asleep	0 1 2 3 4
Feelings of guilt	0 1 2 3 4
Feeling afraid to travel on buses, subways, or trains	0 1 2 3 4
Trouble getting your breath	0 1 2 3 4
Having to avoid certain things, places, or activities	0 1 2 3 4
Your mind going blank	0 1 2 3 4
Numbness or tingling in parts of your body	0 1 2 3 4
The idea that you should be punished for your sins	0 1 2 3 4
Feeling hopeless about the future	0 1 2 3 4
Trouble concentrating	0 1 2 3 4
Feeling weak in parts of your body	0 1 2 3 4
Thoughts of death or dying	0 1 2 3 4
Having urges to beat, injure, or harm someone	0 1 2 3 4
Having urges to break or smash things	0 1 2 3 4
Feeling very self-conscious with others	0 1 2 3 4
Feeling uneasy in crowds	0 1 2 3 4
Never feeling close to another person	0 1 2 3 4
Spells of terror or panic	0 1 2 3 4
Getting into frequent arguments	0 1 2 3 4

Feeling nervous when you are left alone 0 1 2 3 4

Others not giving you proper credit for your achievements 0 1 2 3 4

Feeling so restless you couldn't sit still 0 1 2 3 4

Feelings of worthlessness 0 1 2 3 4

Feeling that people will take advantage of you if you let them 0 1 2 3 4

Having to check and double-check what you do 0 1 2 3 4

The idea that something is wrong with your mind 0 1 2 3 4

Listed below are a number of categories in which people commonly find some difficulties. Please indicate how you are affected by each by circling the appropriate number. Please circle one number for each item.

Not a problem=0 A slight problem=1 A moderate problem=2 A serious problem=3 A severe problem=4

1. YOUR EXPERIENCES AT WORK OR SCHOOL

General performance 0 1 2 3 4

General satisfaction 0 1 2 3 4

Lateness 0 1 2 3 4

Absenteeism 0 1 2 3 4

Negative feelings about work 0 1 2 3 4

Relating to supervisors 0 1 2 3 4

Relating to coworkers 0 1 2 3 4

Other _____ 0 1 2 3 4

2. YOUR BEHAVIOR

Difficulty with daily routines 0 1 2 3 4

Physically abusing others 0 1 2 3 4

Using alcohol or drugs to cope 0 1 2 3 4

Lying 0 1 2 3 4

Stealing 0 1 2 3 4

Other _____ 0 1 2 3 4

3. YOUR FEELINGS AND MOODS

Depression (sadness) 0 1 2 3 4

Euphoria (feeling "high") 0 1 2 3 4

4. YOUR INNER THOUGHTS AND IDEAS

Having repeated unwanted thoughts 0 1 2 3 4

Worrying about your health 0 1 2 3 4

Sudden changes in mood	0 1 2 3 4	Believing you are better than others	0 1 2 3 4
Lack of energy	0 1 2 3 4	Seeing things without apparent cause	0 1 2 3 4
Not liking self	0 1 2 3 4	Hearing things without apparent cause	0 1 2 3 4
Not liking others	0 1 2 3 4	Feeling confused	0 1 2 3 4
Tearful more frequently	0 1 2 3 4	Memory	0 1 2 3 4

INDICATE IF YOU ARE CURRENTLY EXPERIENCING ANY OF THE FOLLOWING HEALTH PROBLEMS:

- Abdominal pain • Eye problems • Skin problems • Backache
- Gastrointestinal problems • Shortness of breath • Change in bowel habits • Headaches
- Ulcers • Change in menstrual pattern • Hearing problems • Nausea or vomiting
- Change in urinary • Hypertension • History of present seizure • Chest pain
- Loss of interest in sex pattern • Colitis disorder • Palpitations (racing heart) • Unable to function sexually
- Cough • Problems with muscles, joints, bones • Weight gain/loss (what period of time? _____)

Do you have any physical handicaps? (describe)

Do you have trouble seeing? _____Hearing?

Have you had any of the following:

Head Injury? _____ Diabetes _____ Learning Disabilities _____
 Cardiac Problems _____

Date of last physical exam (month) _____(year) _____

Current Medication (Names and Dosages):

HAVE ANY OF YOUR RELATIVES HAD:

Alcoholism

Drug Dependency

Mental/Emotional Problems

CLIENT NAME: _____ DATE: _____

ADDRESS: _____ PHONE: _____

City: _____ Zip: _____

10/2/2000