Woodhaven Counseling Associates, Inc.

CURRENT PROBLEM CHECKLIST -- ADULT

NAME: _____ AGE: _____ DATE: _____

Because people experience a wide range of difficulties, the checklist covers many possible problems. Although many of them may not apply to you, please take your time in completing the checklist. This information is very valuable in helping your counselor provide better service to you.

During the past month if you have experienced a problem, circle the "Y." If you have not had the problem during the past month, circle "N."

Y N Lack of energy...easily tired, fatigued/physically tired often
Y N Poor concentration/memory ...can't pay attention/easily distracted/mind goes blank/can't remember
Y N Cannot make decisions...can't figure out what to do as well as I could before
Y N Loss of interest...don't care about things like I used to
Y N Feeling depressed ...feeling blue/low/or down much of the time

Y N Hopelessness ...things just will not work out right in the future/trapped
Y N Crying episodes ...crying easily/wrong time/can't stop crying at times•
Y N Poor appetite...don't eat enough/don't want to eat
Y N Sleep problems...difficulty going to sleep or staying asleep/nightmares/difficulty in waking up
Y N Suicidal thoughts ...wanting to die/sometimes would rather be dead than alive

Y N Angry or irritable ...feel like I want to hurt someone/smash, break things/easily upset/touchy
Y N Restless...can't sit still for long
Y N Periods of feeling lots of energy...hyper /driven/elated/giddy/can accomplish anything
Y N Quick to argue...unusually irritable for days at a time/wanting to fight
Y N Difficulty controlling my actions...acting too quickly/not thinking things through

Y N Tense or anxious...too worried or keyed up about various things
Y N Fear of failure...at school, work/feel unable to succeed
Y N Panic episodes ...become terrified/overwhelmed/very frightened
Y N Intruding thoughts ...can't stop thinking about something or someone
Y N Repeated actions ...need to keep checking on something/need things to be in order

Y N Having experienced or witnessed an event involving actual or threatened death/serious injury
Y N Experiencing recurrent distressing or unwanted dreams/images/thoughts/perceptions

Y N Every day worrying about gaining weight or becoming fat/family or friends commented about weight loss
Y N Vomited or felt the urge to vomit after eating too much
Y N Have used laxatives more than once in the past month

Please continue on the back page

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During the past month if you haven't experienced a problem, circle the "Y." If you have not had the problem during the past month, circle "N."

Y N Physically injured yourself on purpose or otherwise tried to harm yourself

Y N Feeling inferior or easily hurt...others seem unfriendly/don't understand me
Y N Feeling fearful or suspiciousness ...fear something bad will happen/can't trust others/need to be on guard
Y N Loss of control...feel like someone, something i;s controlling my mind
Y N Needing to be punished...fee/ like my sins are unpardonable
Y N Distortions...seeing, hearing, feeling things that are not real

Y N Self-conscious...with others/very uncomfortable when people watch me
Y N Loneliness...feeling like no one cares about me
Y N Feelings of regret...ashamed/guilty/feel like a "bad" person
Y N Bad habits...keep doing things that could cause a serious problem
Y N Unrealistic fears ...afraid of things or people I know won't hurt me

Y N Chronic pain...headaches/stomach problems/beck pain or other physical problems
Y N Heart problems...pounding/skipping beats/painful/racing
Y N Hot - cold flashes ...sweating/chills not related to air temperature
Y N Dizziness/tingling/numbness ...fainting/fear of falling over/things spinning
Y N Sexual problems...having feelings or actions not as they should be/having "bad" habits

Y N Have you ever felt you should cut down on your drinking or drug use?
Y N Have other people annoyed you by criticizing your drinking or drug use?
Y N Have you ever felt guilt about your drinking or drug use?
Y N Have you ever taken a drink in the morning to steady your nerves or get rid of a hangover?

Check if you have received any of the following services and explain below:

☐ - Psychiatric or psychological evaluation
☐ - Drug or alcohol evaluation
☐ - Evaluation or treatment for gambling
☐ - Evaluation, treatment or class for anger control
☐ - Employee Assistance Program (EAP) counseling
☐ - No mental health services whatsoever
☐ - Counseling or psychotherapy
☐ - Drug or alcohol treatment
☐ - Psychiatric hospitalization
☐ - Marital/family counseling

Date From/To	Hospital or Therapist Name	Reason for Service

Thank You