Name____

PROBLEM CHECK LIST (Check all that apply)

ISSUE	PAST PROBLEM	PRESENT PROBLEM
Physical Problem:		
Substance Use:		
Irregular Eating		
Sleep Problem		
Performance at School		
Performance at Home		
Performance at Work		
Making Friends		
Understanding Others		
Shyness		
Feeling Victimized		
Feeling Rejected		
Unable to Have a Good Time		
Feel Cut off from Others		
Communication Problems		
Sexual Problem		
Financial Problem		
Fear of:		
Can't Stop Thinking About:		
Feel Depressed		
Feel Inferior		
Emotionally Numb		
Lack of Confidence		
Excessive Worrying		
Can't Make Decisions		
Don't Like Weekends or Vacations		
Forgetfulness		
Lack of Goals		
Unable to Cope With Day to Day Life		
Afraid of Being on My Own		
Suicidal Thoughts		
Feeling Tense		
Feeling Anxious		
Feeling Angry		
Physical Violence		
Can't Sit Still		
Over-Ambitious		
Unable to Relax		
Seeing or Hearing Things		

Nightmares		
Affairs (emotional, sexual)		
Addiction: substance (alcohol, marijuana, nicotine, etc) , food, sex, shopping, gambling		

Additional Comments: ____

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