

Name: _____

Date: _____

PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY TO YOU AT PRESENT:

- | | |
|---|--|
| <input type="checkbox"/> Suicidal thoughts | <input type="checkbox"/> Feeling easily hurt |
| <input type="checkbox"/> Always tired | <input type="checkbox"/> Lacking confidence |
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Feeling grouchy |
| <input type="checkbox"/> Trouble sleeping | <input type="checkbox"/> Depressed |
| <input type="checkbox"/> Loss of weight | <input type="checkbox"/> Feeling lonely |
| <input type="checkbox"/> Weight gain | <input type="checkbox"/> Not enjoying usual activities |
| <input type="checkbox"/> Fast heartbeat | <input type="checkbox"/> Feeling inferior |
| <input type="checkbox"/> Frequent sweating | <input type="checkbox"/> No one understands me |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Worried about health |
| <input type="checkbox"/> Shaky hands | <input type="checkbox"/> Can't concentrate |
| <input type="checkbox"/> Stomach trouble | <input type="checkbox"/> Can't get going |
| <input type="checkbox"/> Feeling tense | <input type="checkbox"/> Feeling angry |
| <input type="checkbox"/> Cold feet and/or hands | <input type="checkbox"/> Don't like being alone |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Always worried |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Nightmares |
| <input type="checkbox"/> Muscles twitching or jumping | <input type="checkbox"/> Feeling panicky |
| <input type="checkbox"/> Nausea or Vomiting | <input type="checkbox"/> Can't make decisions |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Can't make friends |
| <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Unable to relax |
| <input type="checkbox"/> Chronic illness | <input type="checkbox"/> Feeling fearful |
| <input type="checkbox"/> Full of energy | <input type="checkbox"/> Overly sensitive |
| <input type="checkbox"/> Financial problems | <input type="checkbox"/> Anxious inside |
| <input type="checkbox"/> Marital problems | <input type="checkbox"/> Panic/Anxiety attacks |
| <input type="checkbox"/> Difficulties at work | <input type="checkbox"/> Sexual problems |
| <input type="checkbox"/> Excessive drinking | <input type="checkbox"/> Easily excited |
| <input type="checkbox"/> Excessive use of drugs | <input type="checkbox"/> Quick tempered / lose temper |
| <input type="checkbox"/> Excessive spending of money | <input type="checkbox"/> Impatient with people |
| <input type="checkbox"/> Pornography use | <input type="checkbox"/> Very restless |
| <input type="checkbox"/> Problems with children | <input type="checkbox"/> Feel like hurting someone |
| <input type="checkbox"/> Problems with parents | <input type="checkbox"/> Feel like smashing things |
| <input type="checkbox"/> Fighting and quarreling often | <input type="checkbox"/> Shy with people |
| <input type="checkbox"/> Overly ambitious | <input type="checkbox"/> Loss of meaning of life |
| <input type="checkbox"/> Difficulties at school | <input type="checkbox"/> Feelings of guilt |
| <input type="checkbox"/> Confused about personal religious practice | <input type="checkbox"/> Unable to pray |
| <input type="checkbox"/> Recent loss of someone close to me | <input type="checkbox"/> Unable to forgive |
| <input type="checkbox"/> Crying spells | <input type="checkbox"/> Unable to feel forgiven |
| <input type="checkbox"/> Unable to have fun | <input type="checkbox"/> Loss / disappointment |