Your Name _____ Date_____

Person completing the form (if someone else is completing it for you)_____

Please check the symptoms that occurred in the last 6 months.

Worrying		Hopeless	
Too much energy		Aggressive	
Uncontrolled Temper		Afraid of work	
Excessive crying		Problems sleeping	
Family issues		Nightmares	
Anxiety		Anger	
Jealousy		Separation from spouse or children	
No friends		Mood changes	
Criminal behavior		Excessive lying	
Easily distracted		Problems getting along with others	
No confidence		Stomach pain or constant complaints	
Cutting or self abuse		Verbal abuse of others	
Panic attacks		CPS referrals	
Parenting issues		Afraid to leave the house	
Drug use including marijuana (past or present)		Alcohol abuse (past or present)	
Feeling numb		Grief	
Sleeping too much		Missing work	
Hearing voices		Medical issues	
Promiscuous		Marital issues	
Psychiatric hospitalization		Poor appetite	
Victim of physical abuse		Homicidal ideation (thoughts of hurting others)	
Victim of emotional abuse		Physical abuse of others	
Victim of sexual abuse		Sexual abuse of others	
Other:		Other:	
Other		Other:	

Have you contacted your employee assistance program for help? _____

List any other concerns that you have.

_____

_____

_____