SS-77

HOW OFTEN HAVE YOU BEEN BOTHERED BY THESE SYMPTOMS IN THE PAST FEW WEEKS?

Please use the following guidelines to answer each question,

0 Not at all bothered
1 Slightly bothered
2 More occasionally bothered
3 Moderately Bothered
4 Frequently bothered
5 Constantly bothered
6 Severely bothered

1. Pain in my shoulders ……..……
……..0 1 2 3 4 5 6

2. Headaches……..
……..0 1 2 3 4 5 6

3. Neck and chest pain……..
……..0 1 2 3 4 5 6

4. Not knowing where I am……
……..0 1 2 3 4 5 6

5. Troubling thoughts that repeat themselves……...
……..0 1 2 3 4 5 6

6. Feeling dizzy……
……....0 1 2 3 4 5 6

7. Dry mouth……..……..……..
……..0 1 2 3 4 5 6

8. Feeling restless……..
……..0 1 2 3 4 5 6

9. Less interest in things I used to enjoy……..
……..0 1 2 3 4 5 6

10. Feeling nervous……
……..0 1 2 3 4 5 6

11. Problems from alcohol or taking drugs……..……..0 1 2 3 4 5 6

12. A need to count unimportant items……..0 1 2 3 4 5 6

13. Feeling sick to my stomach……
……..0 1 2 3 4 5 6

14. My mind going blank……..
……..0 1 2 3 4 5 6

15. Feeling guilty about alcohol or drug use……..0 1 2 3 4 5 6

16. Increase in sleep walking……
……..0 1 2 3 4 5 6

17. Try too hard to help others……..
…..0 1 2 3 4 5 6

18. Back pain……
……..0 1 2 3 4 5 6

19. Needing to block out impulsive thoughts……..
……..0 1 2 3 4 5 6

20. Sudden fear of dying……..
……..0 1 2 3 4 5 6

21. Drinking or using drugs too often……..
……..0 1 2 3 4 5 6

22. Problems reading my own handwriting……
……..0 1 2 3 4 5 6

23. Feeling helpless……
……..0 1 2 3 4 5 6

24. Nightmares about something bad that happened to me……..0 1 2 3 4 5 6

25. Talking in my sleep more than usual……0 1 2 3 4 5 6

26. Fears of going outside alone……0 1 2 3 4 5 6

27. Feeling like I am having a heart attack……0 1 2 3 4 5 6

28. Having to repeat certain things I do to avoid getting nervous……..0 1 2 3 4 5 6

29. Feeling sensitive about my faults……0 1 2 3 4 5 6

30. Crying a lot……
……..0 1 2 3 4 5 6

31. Trouble of thinking of names of family members or close friends……0 1 2 3 4 5 6

32. Shortness of breath……
……..0 1 2 3 4 5 6

33. Feeling anxious……
……..0 1 2 3 4 5 6

34. Flashbacks of something bad that happened to me……0 1 2 3 4 5 6

35. Needing to use alcohol or drugs to get high……0 1 2 3 4 5 6

Name_____**Date**_____
___

(over)

36. Being too unselfish for my own ……
……..0 1 2 3 4 5 6

37. Feeling hopeless……..……
……...0 1 2 3 4 5 6

38. Feeling terror……..……
……....0 1 2 3 4 5 6

39. Fear of going crazy…….....……
…….…0 1 2 3 4 5 6

40. Feeling detached from others……..…….0 1 2 3 4 5 6

41. Problems falling or staying asleep……..
…….…0 1 2 3 4 5 6

42. Stomach problems……..
……...0 1 2 3 4 5 6

43. A pounding or racing heart……0 1 2 3 4 5 6

44. Thoughts of hurting or killing myself……..….0 1 2 3 4 5 6

45. Thoughts about something bad that happened to me……..….0 1 2 3 4 5 6

46. The need to keep things extra tidy……..0 1 2 3 4 5 6

47. Not remembering where or when I was born……..0 1 2 3 4 5 6

48. Problems remembering bad things in my life……..0 1 2 3 4 5 6

49. Feeling that things aren't real……..0 1 2 3 4 5 6

50. Needing to repeatedly wash hands……..…….0 1 2 3 4 5 6

51. Stress at work/school or at home……...……..0 1 2 3 4 5 6

52. Arguments with family and friends regarding my alcohol/drug use……
…….0 1 2 3 4 5 6

53. Feeling keyed up or "edgy"
……..……0 1 2 3 4 5 6

54. Trying too hard……
……..0 1 2 3 4 5 6

55. Feeling worthless……
……..…..0 1 2 3 4 5 6

56. Sudden fear for no good reason……..……0 1 2 3 4 5 6

57. Fear of being in a crowded place……0 1 2 3 4 5 6

58. Sadness……0 1 2 3 4 5 6

59. Muscle and body soreness……0 1 2 3 4 5 6

60. Needing to retrace my steps……0 1 2 3 4 5 6

61. Being too honest for my own good……0 1 2 3 4 5 6

62. Using too much alcohol or drugs……0 1 2 3 4 5 6

63. Feeling self – conscious……0 1 2 3 4 5 6

64. Feeling down or “blue” ……0 1 2 3 4 5 6

65. Seeing things that I know aren’t real……0 1 2 3 4 5 6

66. Problems concentrating……0 1 2 3 4 5 6

67. Worry about the future……0 1 2 3 4 5 6

68. Hot or cold feelings in my body……0 1 2 3 4 5 6

69. Needing to drink or use drugs to feel better……0 1 2 3 4 5 6

70. Being too polite to other people……0 1 2 3 4 5 6

71. Feeling ashamed for using drugs or alcohol……0 1 2 3 4 5 6

72. Problems seeing things in color……0 1 2 3 4 5 6

73. Repeated checking of doors or window locks……0 1 2 3 4 5 6

74. Startling easy or feeling jumpy……0 1 2 3 4 5 6

75. Being reminded of something bad that happened to me……0 1 2 3 4 5 6

76. Having to do something many times to keep from getting nervous……..0 1 2 3 4 5 6

77. Spending too much time reading or studying……..0 1 2 3 4 5 6

Name_____ **Date**_____

HISTORY

Name_____Date_____

Reason for starting therapy_____

Problem Areas ____Family _____Work/School _____Anger _____Behavior ____Depression _____Relationships _____Anxiety _____Alcohol/Drugs _____Eating ___Other_____

What do you hope to accomplish in therapy?_____

_____

Physical health problems: Current_____

Past_____

Weight _____Height_____Weight change in last 6 months?_____

Appetite change?_____Food or drug allergies_____

How would you describe the nutritional value/balance of your diet? Good___Fair _____Poor _____

Tobacco use: Current _____Past_____Never_____Packs per day _____Other use?___

Sleep-How many hours per day?_____Problems?_____

Sexual Orientation: Straight___Gay/lesbian__Bisexual_____Not sure_____Transsexual___

Describe any problems with sexual functioning_____

_____

Medication: Name of medication Date How long?
Results
Current: _____
_____

_____
_____

Past: _____
_____

_____
_____

Prior therapy or hospitalization for mental health issues:
Therapist name When How long?
Results

_____
_____

_____
_____

_____
_____

(over)

What was the most helpful, and what was not particularly helpful or effective?

_____
_____

_____
_____

Other family members who have emotional, mental, or substance abuse problems? _____
_____

_____
_____

Have you ever had concerns about your use of alcohol, prescription medications, or other drugs?

Yes___No____ List Concerns _____
_____

Have you ever made a decision to cut down on or quit using alcohol or drugs? Yes_____No
_____

Have you experienced any of the following in connection with your use of alcohol, prescription medications, or other drugs? Check al l that apply:

_____Financial Problems _____Relationship problems _____Work Problems
_____Increased tolerance _____Physical problems _____Emotional Problems
_____Blackouts _____Withdrawal problems _____Cravings

FAMILY: Who lives with you?_____

Any concerns about family members?_____

Have you ever experienced: (optional)
_____Sexual abuse _____Physical abuse
_____Emotional abuse _____Rape/sexual assault _____Domestic violence
_____Sexual harassment _____other significant trauma

Please check which of the following are difficult for you, if any:
_____Budgeting _____Time management _____Communication
_____Leisure _____Self nurturing _____Stress management
_____Food choices _____Parenting

Education_____

Current employment_____

Past employment_____

Any financial problems?_____

Any involvement with the legal system?_____

On probation or parole?_____ Ever been to jail?_____