

PROBLEM CHECK LIST

Name: _____ Date: _____

Below is a list of problems. Please rate each item on a scale of 0 – 4 as shown below.

0 1 2 3 4
(Not a Problem) (A Slight Problem) (A Moderate Problem) (A Serious Problem) (An Extreme Problem)

_____ Difficulty Falling Asleep _____ Vivid Memories of Unpleasant Experiences

_____ Excessive Drinking _____ Excessive Eating

_____ Severe Headaches _____ Difficulty Concentrating

_____ Restlessness _____ No Leisure Activities

_____ Nightmares _____ Suicidal Thoughts

_____ Difficulty Finding a Job _____ Sexual Problems

_____ Difficulty Holding a Job _____ Sleep Issues

_____ Irritability Describe: _____

_____ Pervasive Disgust _____ Self-Consciousness

_____ Memory Loss _____ Depression

_____ Abdominal Discomfort _____ Difficulty Making & Keeping Friends

_____ Management of Money _____ Excessive Jumpiness

_____ Tension and Anxiety _____ Loss of Weight/Appetite

_____ Physical/Medical Problems _____ Panic Attacks

Specify: _____ _____ Problems with “authority figures”

_____ Hostility _____ Avoidance of Activities that Remind you
Of Prior Unpleasant Events

_____ Marital Problems _____ Trouble Trusting Others

_____ Easily Fatigued _____ Lost of Interest in Usual Activities

_____ Drug Use/Abuse _____ Problems with Prescription Drugs

_____ Inability to Express Feelings _____ Feeling Emotionally Numb