PROBLEM CHECK LIST

Name ____ Date______________

Below is a list of problems Please rate each item on the scale of 0 - 4 listed below.

0	1	2	3	4
not a problem	a slight problem	a moderate problem	a serious problem	an extreme problem

____ difficulty falling asleep

____ abusive drinking

____ severe headaches

____ restlessness

____ nightmares

____ difficulty finding a job

____ difficulty holding a job

____ irritability

____ pervasive disgust

____memory loss

____ abdominal discomfort

____ management of money

____ trapped in an unsatisfying job

____ physical/medical problems

specify: _____________________

____ hostility

____ marital problems

____ easily fatigued

____ drug abuse

____ inability to express feelings

____ tension and anxiety

____ vivid memories of unpleasant experiences

____ excessive eating

____ difficulty concentrating

____ no leisure activities

____ suicidal thoughts

____ sexual problems

____ sleep issues

describe: ______________________________

____ self-consciousness

____ depression

____ ability to make & keep friends

____ excessive jumpiness

____loss of weight / appetite

____ panic attacks

____ problems with “authority” figures

____ avoidance of activities that remind of prior unpleasant events

____ trouble trusting others

____ loss of interest in usual activities

____ problems with prescription medications

____ feeling emotionally numb