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BACKGROUND INFORMATION

Name: _____

Have you experienced any of the following during the last year? Please check all that apply.

SLEEP PROBLEMS:
____difficulty falling asleep
____waking in the night
____nightmares/bad dreams
____don't feel rested
____sleeping too much

NERVOUSNESS/ANXIETY:
____feeling worried/nervous
____shortness of breath
____tightness in chest
____rapid heartbeat
____fears or phobias (describe):
_____
_____

PHYSICAL PROBLEMS:
____backaches
____headaches
____stomach problems
____high blood pressure
____irritable/spastic bowel
____other medical conditions
(describe): _____
_____
_____
_____

APPETITE/EATING PROBLEMS:
____eating too much or when not hungry
____eating too little/restricting
____poor appetite
____using laxatives or vomiting
____weight gain
____weight loss

SADNESS/DEPRESSION:
____feeling down/blue/depressed
____crying spells/tearfulness
____feeling hopeless or helpless
____feeling suicidal or like giving up
____low energy or fatigue
____feeling flat/numb/dull

SEXUAL PROBLEMS:
____performance problems
____loss of interest in sex
____increased interest in sex
____difficulty with erection
____painful intercourse
____lack of pleasure in intercourse

OTHER:
____problems with concentration/memory
____problems getting motivated
____irritability
____angry outbursts
____frequent fights with others
____difficulties in relationships
____anything else? (describe):
_____
_____
_____

Do you use alcohol? YES NO How many times/week? _____ No. of drinks: _____
Do you use any non-prescription drugs? YES NO

If so, which ones and how often? _____

_____

Do you or someone close to you ever worry about your drug or alcohol use? YES NO

Previous mental health hospitalization? YES NO

If so, when and for what reason? _____

Family history of mental health or alcohol and/or drug problems? YES NO

If yes, explain: _____

_____