

DIANE FARRINGTON CURTIS MA, LPC
SYMPTOM IDENTIFICATION

NAME: _____

DATE: _____

INSTRUCTIONS: Below is a list of problems and areas of life functioning in which some people experience difficulties. Using the scale given below, CIRCLE THE ANSWER that best describes the degree of difficulty you have been experiencing in each area during the PAST WEEK. If there is an area that you consider to be inapplicable, indicate that it is *No Difficulty*.

For each question, please circle one and only one response scale number.

0=No difficulty, 1=A little difficulty, 2=Moderate difficulty, 3=Quite a bit of difficulty, 4=Extreme difficulty

To what extent are you experiencing difficulty in the area of:

1. Managing day-to-day life. (i.e.-getting places on time, handling money, making everyday decisions).....0 1 2 3 4
2. Household Responsibilities. (i.e.-shopping, cooking, laundry, cleaning, other chores).....0 1 2 3 4
3. Work. (i.e.-completing tasks, performance level, finding/keeping job)0 1 2 3 4
4. School. (i.e.-academic performance, completing assignments, attendance)0 1 2 3 4
5. Leisure time or recreational activities.....0 1 2 3 4
6. Adjusting to major life stresses. (i.e.-separation, divorce, moving, new job, new school, a death)0 1 2 3 4
7. Relationships with family members.....0 1 2 3 4
8. Getting along with people outside of the family.....0 1 2 3 4
9. Isolation or feelings of loneliness.....0 1 2 3 4
10. Being able to feel close to others.....0 1 2 3 4
11. Being realistic about yourself or others.....0 1 2 3 4
12. Recognizing and expressing emotions appropriately.....0 1 2 3 4
13. Developing independence.....0 1 2 3 4
14. Goals or direction in life.....0 1 2 3 4
15. Lack of self-confidence, feeling bad about yourself.....0 1 2 3 4
16. Apathy, lack of interest in things.....0 1 2 3 4
17. Depression, hopelessness.....0 1 2 3 4
18. Suicidal feelings or behavior.0 1 2 3 4
19. Physical symptoms. (i.e.-headaches, aches and pains, sleep disturbance, stomach aches, dizziness)0 1 2 3 4

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- 20. Fear, anxiety or panic.....0 1 2 3 4
- 21. Confusion, concentration, memory.....0 1 2 3 4
- 22. Disturbing or unreal thoughts or beliefs.....0 1 2 3 4
- 23. Hearing voices, seeing things.....0 1 2 3 4
- 24. Manic, bizarre behavior.....0 1 2 3 4
- 25. Mood swings, unstable moods.....0 1 2 3 4
- 26. Uncontrollable, compulsive behavior. (i.e.-eating disorder, hand-washing, hurting yourself).....0 1 2 3 4
- 27. Sexual activity or preoccupation.....0 1 2 3 4
- 28. Drinking alcoholic beverages.....0 1 2 3 4
- 29. Taking illegal drugs, misusing drugs.....0 1 2 3 4
- 30. Controlling temper, outburst of anger, violence.....0 1 2 3 4
- 31. Impulsive, illegal or reckless behavior.....0 1 2 3 4
- 32. Feeling satisfaction with your life.....0 1 2 3 4
- 33. How old were you on your last birthday?

For the following questions, please circle the appropriate response code.

- 34. What is your sex? 1=Male 2=Female..... 1 2
- 35. Marital status. 1=Never married 2=Married 3=Separated/divorced/widowed..... 1 2 3
- 36. In the past 30 days, what were your usual living arrangements? 1 2 3 4 5
1=Alone, 2=With family, 3=Halfway house/Treatment setting, 4=With non-relative, 5=Other
- 37. In the past 30 days, were you working at a paid job? 1=Yes 2=No..... 1 2
- 38. If Yes, how many hours per week? (If No, leave unanswered.)1 2 3 4
1=Less than 10, 2=11-20 hours, 3=21-30 hours, 4=More than 30 hours
- 38. In the past 30 days, were you a student attending a high school, vocational training program, college or graduate degree program? 1 2
1=Yes 2=No

END OF SURVEY. THANK YOU.