

# BEHAVIORAL HEALTH QUESTIONNAIRE

Name:

Date:

Please check any symptoms you may be experiencing today or on a regular basis over the past two weeks. Then put a star next to the three which cause you the most problem and interfere with your life the most.

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| <input type="checkbox"/> Poor appetite and/or weight loss*                         | <input type="checkbox"/> Binge eating  |
| <input type="checkbox"/> Overeating and/or weight gain*                            | <input type="checkbox"/> Regular use of laxatives  |
| <input type="checkbox"/> Difficulty falling asleep or staying asleep*              | <input type="checkbox"/> Other eating disorder   |
| <input type="checkbox"/> Sleeping too much*  | <input type="checkbox"/> Excessive exercising  |
| <input type="checkbox"/> Feelings of worthlessness*                                | <input type="checkbox"/> Self-induced vomiting   |
| <input type="checkbox"/> Crying spells   | <input type="checkbox"/> Self-mutilation   |
| <input type="checkbox"/> Low self-esteem   | <input type="checkbox"/> Often angry   |
| <input type="checkbox"/> Difficulty breathing                                      | <input type="checkbox"/> Physically aggressive toward others                                     |
| <input type="checkbox"/> Fear of loss of control or going crazy                    | <input type="checkbox"/> Swearing or name calling during arguments                               |
| <input type="checkbox"/> Sadness, loneliness*                                      | <input type="checkbox"/> Throwing or breaking things during arguments                            |
| <input type="checkbox"/> Difficulty making decisions                               | <input type="checkbox"/> Inattentive   |
| <input type="checkbox"/> Trouble concentrating*                                    | <input type="checkbox"/> Careless mistakes   |
| <input type="checkbox"/> Irritability  | <input type="checkbox"/> Forgetful   |
| <input type="checkbox"/> Feelings of hopelessness*                                 | <input type="checkbox"/> Disorganized  |
| <input type="checkbox"/> Suicidal thoughts**                                       | <input type="checkbox"/> Easily distracted   |
| <input type="checkbox"/> Suicidal plan**   | <input type="checkbox"/> Trouble listening   |
| <input type="checkbox"/> History of suicide attempts                               | <input type="checkbox"/> Avoid/dislike mental tasks  |
| <input type="checkbox"/> Homicidal thoughts  | <input type="checkbox"/> Often lose things   |
| <input type="checkbox"/> Lack of interest or motivation                            | <input type="checkbox"/> Feel driven/on the go   |
| <input type="checkbox"/> Anxiety*  | <input type="checkbox"/> Hyperactivity*  |
| <input type="checkbox"/> Loss of interest in sex                                   | <input type="checkbox"/> Fidget a lot  |
| <input type="checkbox"/> Loss of enjoyment in usual activities*                    | <input type="checkbox"/> Often interrupt people/blurt out answers before questions are completed |
| <input type="checkbox"/> Isolation from friends and family                         | <input type="checkbox"/> Impulsive   |
| <input type="checkbox"/> Poor self-care, cleanliness, hair appearance              | <input type="checkbox"/> Anger outbursts   |
| <input type="checkbox"/> Muscle tension  | <input type="checkbox"/> Nightmares related to past trauma                                       |
| <input type="checkbox"/> Restlessness or feeling agitated*                         | <input type="checkbox"/> Recurrent/distressful thoughts of past trauma                           |
| <input type="checkbox"/> Trouble getting along with people                         | <input type="checkbox"/> Acting/feeling as if re-experiencing past trauma                        |
| <input type="checkbox"/> Tire easily*  | <input type="checkbox"/> Repeating behaviors like counting or checking                           |
| <input type="checkbox"/> Low energy*   | <input type="checkbox"/> Significant debt or relationship problems due to gambling               |
| <input type="checkbox"/> Racing heartbeat  | <input type="checkbox"/> Gambling to escape problems   |
| <input type="checkbox"/> Tightness in chest  | <input type="checkbox"/> Excessive pre-occupation with sex                                       |
| <input type="checkbox"/> Fear of having heart attack or dying                      | <input type="checkbox"/> Excessive shopping  |
| <input type="checkbox"/> Numbness or tingling sensations                           | <input type="checkbox"/> Use of alcohol/drugs to feel better                                     |
| <input type="checkbox"/> Headaches   | <input type="checkbox"/> Hearing voices/sounds that might not be there                           |
| <input type="checkbox"/> Chills or hot flashes                                     | <input type="checkbox"/> Seeing things that might not be there                                   |
| <input type="checkbox"/> Digestive or GI problems                                  | <input type="checkbox"/> Other types of hallucinations   |
| <input type="checkbox"/> Menstrual problems  |  |
| <input type="checkbox"/> Frequent pain (where?)*                                   |  |
| <input type="checkbox"/> High risk activities (business, financial, legal, sexual) |  |
| <input type="checkbox"/> Excessive spending  |  |
| <input type="checkbox"/> Racing thoughts   |  |
| <input type="checkbox"/> Talking too fast  |  |
| <input type="checkbox"/> Shoplifting or stealing                                   |  |
| <input type="checkbox"/> Very little need for sleep, (2-3 hrs/night)*              |  |

THINGS THAT ARE STRESSFUL TODAY:

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(Thanks to Noel Holdsworth, DNH, PMHNP, BC, CTS, for the creation of this checklist)