

CompassionWorks

Jordan Shafer, MS, LPC
(972) 342-2448 Appointments
972 (527) 9563 (fax)

Presenting Issues Questionnaire

Name: _____

Date: _____

Only check "yes" if the issue described cause you significant distress and/or cause problems at home, work or in relationships.

Yes	No	Do you frequently have difficulty getting to sleep or staying asleep?
Yes	No	Does lack of sleep make you feel unrested or cause you to function poorly during the day?
Yes	No	Do you have anxiety or worry excessively (more than the average person) about things such as work, finances, loved ones?
Yes	No	Do you find it difficult to control worry and anxiety?
Yes	No	Do you have unexpected or "out of the blue" periods of intense fear associated with symptoms such as shakiness, shortness of breath, and/or racing heart?
Yes	No	Do you experience intense feelings of anxiety or fear that you will be humiliated or embarrassed in front of others?
Yes	No	Do you avoid or anxiously endure things such as speaking in public, parties, dating, writing or eating in front of others?
Yes	No	Are you bothered by intrusive thoughts or mental images?
Yes	No	Do you have to perform repetitive behaviors (e.g. hand washing or checking), or mental rituals (e.g. counting, repeating words) to control your anxiety or distress?
Yes	No	Have you experienced a traumatic event(s) that threatened or actually caused serious physical injury to yourself or others?
Yes	No	As a result, do you have significant stress such as flashbacks, nightmares, persistent anxiety, or feelings of emotional numbness?
Yes	No	Do you have times when you feel depressed or down most of the day, nearly every hour?
Yes	No	Have you lost interest, motivation, or pleasure in usual activities?

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Yes	No	Do you have chronic difficulties paying attention?
Yes	No	Do you find it hard to be still?
Yes	No	Do you sometimes act before you think?

Yes	No	Do you have distinct periods of time when you are different than your normal self – you either feel high/full of energy, or are persistently angry?
Yes	No	Does this behavior cause you, or others, problems? (Don't include alcohol or drug related states.)

Yes	No	Have you, or others, been concerned about your alcohol consumption?
Yes	No	Have you tried to cut down or felt guilty about drinking alcohol?

Yes	No	Do you have eating binges at times when you eat a very large amount of food within a two-hour period?
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Yes	No	Do you use tobacco (cigarettes, snuff, chewing tobacco)?
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Yes	No	Do you take drugs to get high, feel better, or change your mood?
Yes	No	Do you use illegal drugs?

Yes	No	Do you have a lack or lost of interest in sex or decreased arousal?
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Yes	No	Have other people expressed concern that you are too thin?
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Yes	No	When you were a child, and perhaps as an adult, did you have difficulty making friends, or did you not want to make friends?
Yes	No	Did you have, and perhaps still do, difficulty understanding other people's feelings
Yes	No	Did you have, and perhaps you still do, a special interest(s) that took up much of your time?