General Questionnaire

Client Name _____ **Date** _____

If you are 13 or older, please complete this section

The following questions are about common psychological, behavioral or personal problems. These problems are considered significant when you have them for two or more weeks, when they keep coming back, when they keep you from meeting your responsibilities, or when they make you feel like you can't go on. Please answer the next questions using Yes or No.

1. During the past 12 months, have you had significant problems…

a. with feeling very trapped, lonely, sad, blue, depressed, or hopeless about the future? ☐ Yes ☐ No

b. with sleep trouble, such as bad dreams, sleeping restlessly or falling asleep during the day? ☐ Yes ☐ No

c. with feeling very anxious, nervous, tense, scared, panicked or like something bad was going to happen? ☐ Yes ☐ No

d. when something reminded you of the past, you became very distressed and upset? ☐ Yes ☐ No

e. with thinking about ending your life or committing suicide? ☐ Yes ☐ No

2. During the past 12 months, did you do the following things two or more times?

a. Lie or con to get things you wanted or to avoid having to do something? ☐ Yes ☐ No

b. Have a hard time paying attention at school, work or home? ☐ Yes ☐ No

c. Have a hard time listening to instructions at school, work or home? ☐ Yes ☐ No

d. Been a bully or threatened other people? ☐ Yes ☐ No

e. Start fights with other people? ☐ Yes ☐ No

3. During the past 12 months, did…

a. you use alcohol or drugs weekly? ☐ Yes ☐ No

b. you spend a lot of time either getting alcohol or drugs, using alcohol or drugs, or feeling the effects of alcohol or drugs (high, sick)? ☐ Yes ☐ No

c. you keep using alcohol or drugs even though it was causing social problems, leading to fights, or getting you into trouble with other people? ☐ Yes ☐ No

d. your use of alcohol or drugs cause you to give up, reduce or have problems at important activities at work, school, home or social events? ☐ Yes ☐ No

e. you have withdrawal problems from alcohol or drugs like shaking hands, throwing up, having trouble sitting still or sleeping, or use any alcohol or drugs to stop being sick or avoid withdrawal problems? ☐ Yes ☐ No

The information in this questionnaire form is complete and accurate to the best of my knowledge.

Client Signature: **X**	Date: