BRYCE KAYE & ASSOCIATES

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SAFETY ISSUES & SYMPTOMS QUESTIONNAIRE

Name: ______________________________ **Date:** ______________________
(Please Print)

	YES	NO
Any previous suicide attempts?	____	____
Any previous intentional self-inflicted injuries?	____	____
Recent thoughts of suicide or self-injury?	____	____
Previous history of violence towards another?	____	____
Recent thoughts of violence towards another?	____	____
Recent abuse of alcohol or other substances?	____	____
Any history of prior DUI charge?	____	____
Previous substance abuse treatment?	____	____
Are you currently involved in any legal action?	____	____
Previous psychiatric treatment?	____	____
Previous psychiatric hospitalization?	____	____
Possible threat of violence in current living situation?	____	____

Current physical illnesses: ____

When was approximate date of your last physical exam? ______________________

When was the last date you saw your doctor? ______________________________

Please list all current medications:

Medication	Dosage & Frequency	Date Started	Prescribed by whom,? (Full Name)

NOW PLEASE ANSWER QUESTIONS ON THE REVERSE SIDE

What is your primary goal that you want counseling to help you achieve?

____

____

Considering the past several weeks, please rate the presence or degree that you experienced each of the following symptoms. (Circle your answer)

	NONE	SLIGHT	MODERATE	SEVERE	EXTREME
GENERAL ANXIETY	0	1	2	3	4
SPECIFIC UNRREALISTIC FEARS	0	1	2	3	4
MARITAL/RELATIONSHIP PROBLEMS	0	1	2	3	4
DEPRESSED MOODS	0	1	2	3	4
THOUGHTS OF HURTING OTHERS	0	1	2	3	4
THOUGHTS OF SUICIDE	0	1	2	3	4
If any, when was last date? ___________					
Did you think of a plan? Yes: ___ No: ___					
PHYSICAL AGRESSION TOWARD ANOTHER	0	1	2	3	4
GENERAL HOSTILITY TOWARD OTHERS	0	1	2	3	4
PROCRASTINATION/WORK INHIBITION	0	1	2	3	4
ALCOHOL/DRUG ABUSE	0	1	2	3	4
HALLUCINATIONS/DELUSIONS	0	1	2	3	4
REPETITIVE UNWANTED THOUGHTS	0	1	2	3	4
REPETITIVE UNWANTED BEHAVIORS	0	1	2	3	4
ANGER MANAGEMENT PROBLEMS	0	1	2	3	4
MISBEHAVIOR/ CONDUCT PROBLEMS	0	1	2	3	4
CONSENTRATION/ MEMORY PROBLEMS	0	1	2	3	4
OVER-SENSITIVE ABOUT WHAT OTHER SAY TO YOU	0	1	2	3	4
LOSS OF DAILY ENERGY	0	1	2	3	4
LOSS OF CONCENTRATION	0	1	2	3	4
FEELING OF WORTHLESSNESS	0	1	2	3	4
PARANOIA OR DELUSIONAL THINKING	0	1	2	3	4
A DECREASE IN SLEEP	0	1	2	3	4
How many hours do you average? _____					
LOSS OF APPETITE WITH WEIGHT LOSS	0	1	2	3	4
If weight loss, how many lbs? _________					
LOSS OF INTEREST IN PLEASURABLE ACTIVITY	0	1	2	3	4
PANIC ATTACKS WITH HYPERVENTILATION	0	1	2	3	4
If any, how often per week? ___________					

Thank you for your hard work!

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(Please sign here)