Name: _____ **Date:** _____

Use either the severity scale (1 for not a problem; 4 for severe) or the frequency scale to answer how much of a problem each of these were in the last month. Use the back of the form to explain further if needed.

How bad?	1	2	3	4
How often?	Never or rarely	Sometimes	Often	Usually/ Daily
Low energy level				
Fatigue				
Sleep problems (if you answered 3 or 4, please answer the following too)				
Trouble falling asleep				
Trouble falling back to sleep				
Interrupted sleep				
Early waking				
Restless legs				
Snoring				
Not feeling rested after sleep				
Sleeping too much				
Headache				
Joint pains				
Numbness/tingling/weakness (Where?)				
Reduced exercise capacity				
Dissatisfied with current weight				
Weight changes				
Decreased appetite				
Increased appetite				
Change in libido (sexual appetite)				
Increased anger/irritability				
Decreased attention/concentration				
Feeling sad or depressed				
Feeling worried or anxious				
Change in use of addictive substances				
Use of illegal drugs				
Drinking more than 2 alcoholic drinks at one time (if you answered 3 or 4, please also answer the next 4 questions)				
Felt you should cut down				
Felt annoyed by people criticizing your drinking?				
Felt bad or guilty about drinking				
Had a drink first thing upon waking up				
Smoking, vaping, used smokeless tobacco				
Problems with spouse/partner				
Significant problems with children				
Serious financial stressors				
Less interest in hobbies/usual recreation				
Less involvement with friends/organizations/ church				
Work schedule problems				
High stress at work				
Lack of support, or friction with others, at work				
High physical demands at work				

If you are not working right now, please indicate how soon you expect to be able to return to your regular work:

☐ Next 2 weeks ☐ Next 2 months ☐ I don't know ☐ I don't expect to ☐ Other: _____