



THE PRIVATE PRACTICES OF

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In the past TWO WEEKS were you distressed by the following?

Adolescents please complete one for yourself, and parents, please complete a separate one based upon your observations of your child.

- | | | |
|--|--|--|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Difficulty concentrating | <input type="checkbox"/> Feeling that others are talking about you |
| <input type="checkbox"/> Feeling nervous and shaky | <input type="checkbox"/> Thoughts of ending my life | <input type="checkbox"/> The idea that someone else can control your thoughts |
| <input type="checkbox"/> Worrying all the time | <input type="checkbox"/> Thoughts of cutting self | <input type="checkbox"/> Feeling that people are unfriendly or dislike you |
| <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Cutting self | <input type="checkbox"/> Having to avoid certain things, places, or activities because they frighten you |
| <input type="checkbox"/> Shyness | <input type="checkbox"/> Thoughts of harming others | <input type="checkbox"/> Things around you seem surreal |
| <input type="checkbox"/> Muscles are always tense | <input type="checkbox"/> Feeling hopeless about future | <input type="checkbox"/> Trouble with sleeping |
| <input type="checkbox"/> Faint or dizziness | <input type="checkbox"/> Feeling worthlessness | <input type="checkbox"/> Always running late |
| <input type="checkbox"/> Pains in heart/chest | <input type="checkbox"/> Low self esteem | <input type="checkbox"/> Procrastination |
| <input type="checkbox"/> Stomach discomfort or changes to bowels | <input type="checkbox"/> No fun in life | <input type="checkbox"/> Flashbacks of past |
| <input type="checkbox"/> Difficulty leaving home | <input type="checkbox"/> Weight loss | <input type="checkbox"/> Nightmares |
| <input type="checkbox"/> Isolating self | <input type="checkbox"/> Weight gain | <input type="checkbox"/> Academic concerns |
| <input type="checkbox"/> Checking things over and over | <input type="checkbox"/> Feelings of guilt | <input type="checkbox"/> Financial worries |
| <input type="checkbox"/> Cleaning self all the time | <input type="checkbox"/> Difficulty with anger management | <input type="checkbox"/> Work concerns |
| <input type="checkbox"/> Hoarding things | <input type="checkbox"/> Feelings of irritability | <input type="checkbox"/> Relationship worries |
| <input type="checkbox"/> Feeling easily annoyed or irritated | <input type="checkbox"/> Often missing shower or bath | <input type="checkbox"/> Sexual Difficulties |
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Purging | <input type="checkbox"/> An important loss |
| <input type="checkbox"/> Increased appetite | <input type="checkbox"/> Excessive use of laxatives | <input type="checkbox"/> Problems related to drinking |
| <input type="checkbox"/> Lack of energy | <input type="checkbox"/> Restricting Food | <input type="checkbox"/> Problems related to drugs |
| <input type="checkbox"/> Chronic pain | <input type="checkbox"/> Binge Eating | <input type="checkbox"/> Problems with gambling |
| <input type="checkbox"/> Difficulty being with people | <input type="checkbox"/> Exercising excessively | |
| <input type="checkbox"/> Crying more than usual | <input type="checkbox"/> Menstrual problems | |
| <input type="checkbox"/> Feeling fearful | <input type="checkbox"/> Feeling that you are watched | |
| <input type="checkbox"/> Feeling inferior to others | <input type="checkbox"/> Feeling others are to blame for most of your troubles | |

Drug Use

- Frequent
 Sometimes
 Never

Alcohol Use

- Frequent
 Sometimes
 Never

Exercise

- Frequent
 Sometimes
 Never

Pregnant

- Yes
 No