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Problem Rating Inventory for Adults

Name: _____ Date: _____ Date of Birth: _____

Please list or describe below your main concerns:

1.

2.

3.

DIRECTIONS

The following questions are grouped by sections. Not all sections of this inventory apply to everyone. At the top of each section, there is a statement describing a general area of concern. If you are confident that the area is not a concern for you, mark the "No Concern" blank and skip to the next section. If you are not sure, read over the items, and respond to the items that apply.

Each page also has a blank area where you can write explanations or examples if you wish.

Addictive Activities

No Concerns _____

The following are a list of activities that people sometimes feel are addictive. If you have no concerns, check the “No Concerns” blank above:

	No problem	Minor concern	Major concern
Television			
Video games/ computer games			
Problems with internet socializing			
Excessive interest in one or a few activities			
Fantasy role-playing games (e.g., Dungeons and Dragons, Magic)			
Pornography			
Other hobby, interest, or activity: _____			
Eating or exercise habits			
Gambling			
Shopping			

Circle the setting(s) where these problems occur: Home Work/School Social settings / Community

Please comment on when these problems began and whether they are getting better or worse.

Specific Learning Problems

No Concerns _____

If you were able to get acceptable grades in all subjects without help, keep track of assignments, and succeed in academic activities, please check “No Concerns” above and skip to the next section.

Otherwise, please answer the following items:

	No Concern	Minor Concern	Major Concern
Problems with learning to read			
Problems sounding out the parts of words			
Leaves out or inserts words while reading aloud			
Reads very slowly			
Problems remembering or understanding what was read			
Problems with mathematics			
Math word/story problems			
Problems calculating numbers			
Penmanship			
Problems with writing letters/numbers upside down or backwards			
Arranges letters incorrectly when writing (e.g., callte for cattle, gonig for going)			
Spelling			
Copying from the board			
Getting ideas down on paper			
Expressing self by talking			
Expressing self in writing			
Big difference between written and verbal skills; one is strong and the other weak			
Problems remembering to bring assignments or books home or back to school			
Problems completing assignments			
Backpack, desk, or locker is disorganized and messy			
Problems using daily planner			

Please comment on when these problems began and whether they are getting better or worse:

Please tell how you've tried to help and what has worked or not worked:

Habit, Tic Disorders, and Other Body Problems

No Concerns _____

If you do not have problems with unusual muscle movements, nervous habits, problems with bowels, or injuring yourself, please check “No Concerns” above and skip to the next section.

Otherwise, please rate the following items:

	Never	Occasionally, but not a problem	A few times a month	Twice a week or more
Rapid, repetitive muscle twitches (muscle tics) like: exaggerated or repetitive eye blinking, sniffing/snorting, head tossing				
Frequent physical restless movements: bouncing leg, tapping fingers				
Repeated shouting, mumbling, or cursing that seems to be involuntary				
Compulsive rituals, such as having to touch or tap things in a particular way or a certain number of times				
Pulls out own hair, eyelashes, or eyebrows				
Biting nails				
Picking at skin				
Cutting or burning self on purpose				
Engages in excessive or public masturbation				
Other habits or movements: _____				

Circle the setting(s) where these problems occur: Home Work/School Social settings / Community

Please comment on when these problems began and whether they are getting better or worse:

Problems with Social Skills and Adapting

No Concerns _____

If you are able to fit in with peers, have a variety of interests, and adapt well to changes or new settings, please check “No Concerns” above and skip to the next section.

Otherwise, please rate the child or teen on the following items:

	Not observed	Some, but not a problem	Minor concern	Major concern
Interacts with peers in an awkward or inappropriate way				
Trouble talking about or explaining emotions/feelings				
Difficulty sustaining a back-and-forth conversation				
Doesn't care to share interests with others				
Isn't interested in interacting with peers				
Minimal eye contact when talking with someone				
Uses odd tone of voice or inappropriate volume				
Doesn't understand slang, jokes, or intended comments – takes things too literally				
Trouble reading nonverbal cues (facial expressions, tone of voice, body language)				
Minimal hand gestures, change of voice tone, or facial expressions when talking				
Difficulty making friends				
Difficulty keeping friends				
Difficulty understanding friendship boundaries				
Difficulty adjusting behavior to suit different social situations				
Not interested in associating with peers outside of school				
Repetitive movements (rocking, flapping hands, pacing)				
Repetitive use of objects (lining up toys, spinning a toy over and over, etc.)				
Repetitive speech (repeating some phrase with unusual frequency, etc.)				
Insists on keeping things the same – strongly dislikes change				
Gets upset when nonfunctional routines are not adhered to				
Ritualized behaviors (has to do things in a particular, prescribed way)				
Rigid/stubborn way of seeing things				
Overly attached to or overly interested in unusual objects				
Very limited number of interests				
Preoccupied or overly fixated on certain topics of interest				
Indifference to pain or temperature				
Excessive interest or attraction to certain textures or touching objects				
Excessive interest with visual stimuli (flickering lights, spinning objects, etc.)				
Excessive smelling of certain objects				
Overly upset by loud or chaotic sounds				
Overly sensitive to odors				
Overly sensitive to certain food textures				
Overly sensitive to certain clothing material, shirt tags, or sock seams				
Seems unaware of what's happening – doesn't “get the big picture”				
Physically clumsy – has difficulty with athletics				
Has unacceptable social habits, such as poor hygiene, nose picking, etc.				

Please comment on when these problems began and whether they are getting better or worse:

Any other problems with social skills?

Anxiety Symptoms

No Concerns _____

If you are able to handle frustrations well, and do not show more than a typical response when frightened or worried, please check “No Concerns” above and skip this section.

Otherwise, please rate the following items:

	Never	Somewhat, but not a problem	Minor concern	Major concern
Sometimes won't go with friends or participate in sports or other activities because of being shy or insecure				
Worries too much or has unrealistic worries				
Marked feelings of tension: seems unable to relax				
Has panic attacks or other distinct episodes of intense anxiety				
Has physical symptoms of stress such as headaches or stomach aches, without a known medical cause				
Gets too upset when separated from loved ones				
Worries a lot about family members when they are away from home				
Sometimes won't go to work or school because of stress or anxiety				
Has excessive fears, such as fear of the dark, storms, elevators, dentists, dogs, insects, etc.				
Too worried about germs or illness				
Repeatedly ask for reassurance, even though others have reassured me many times before				
Can't get certain thoughts out of my head				
Insist on having things done a certain way and get anxious or angry if I don't get my way				
Does things over and over again or takes an excessive amount of time, such as washing hands, showering, praying, checking things, etc.				

Circle the setting(s) where these problems occur: Home Work/School Social settings / Community

Please comment on when these problems began and whether they are getting better or worse:

Signs or Symptoms of Stress Resulting from Trauma:

No Concerns _____

This section is for those involved in serious or life-threatening situations, witnessed another person being injured or killed, or who have been victims of abuse or witnessed the abuse of someone else. If this is not a concern for you, please check “No Concerns” above and skip this section.

Experienced one or more of the following:

Please check all that apply	
	Tornado, flood, or natural disaster when important possessions were threatened or lost
	House fire
	Car accident in which someone was injured
	Saw someone get seriously injured
	Was involved in a “close call” in which a someone might have died
	Had a medical procedure which was extremely painful, frightening, or required restraints
	Witnessed a loved one in an accident or life-threatening illness
	Regularly or seriously victimized by teasing, bullying, or harassment at school
	Was a victim of a crime: mugging, molestation, kidnapping, or other
	Was attacked by a dog or other animal
	Had an accident in the home, which resulted in injury or scarring
	Witnessed severe arguments in the home in which adults shouted, swore, threatened one another
	Witnessed violence in the home: shoving, hitting, slapping, or worse
	Victim of physical abuse
	Victim of emotional abuse
	Victim of sexual abuse
	Not sure, but suspect I may have been abused

Please complete these questions regarding observations since the distressing event(s):

Please check all that apply	
	Act out, talk about, or replay in my mind the distressing event over and over again
	Recurring nightmares
	Episodes in which I feel like I was back in the distressing event (flashbacks)
	Intense distress or fear when something reminds me of the distressing event
	Avoids or refuses to talk or think about what is bothering me (“shuts down”)
	Avoids situations, people, or places that remind me of the distressing event
	Unable to recall important parts of the distressing event
	Tendency to keep to myself; not interested in some activities since the distressing event
	Shows a restricted range of feelings (blunted emotion); or had a change in personality after the event
	Limited interest in planning for the future; not excited or interest in my future since the event
	Increased difficulty falling or staying asleep after the distressing event
	Increased angry outbursts or irritability after the event
	Always vigilant; feel I have to be on guard; uncomfortable or feel unsafe in new settings
	Exaggerated startle response (“jumpy”)

Inattentive, Hyperactive, or Impulsive Behaviors:

No Concerns _____

If you are able to stay focused on boring tasks, pay attention during uninteresting conversations, show good independence and organization throughout the day at both home and work/school check “No Concerns” above and skip this section.

Otherwise, please rate the following items:

	Never or Rarely	Sometimes	Often	Very Often
Fails to give close attention to details or makes careless mistakes at work, in school, or other activities				
Has trouble maintaining attention in tasks or play activities				
Does not seem to listen when spoken to directly				
Does not follow through on instructions & fails to finish schoolwork, chores, etc.				
Difficulty organizing tasks and activities				
Avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as school work or homework)				
Loses things necessary for tasks or activities (e.g. school supplies, toys, gloves)				
Easily distracted				
Forgetful in daily activities				
Fidgets with hands or feet or squirms in seat				
Leaves seat in situations when expected to remain seated				
Feels excessively restless in situations where it is inappropriate				
Difficulty playing or engaging in leisure activities quietly				
Always "On the go", acts as if "driven by a motor"				
Talks excessively				
Blurts out answers to questions before they have been completed				
Difficulty waiting his or her turn				
Interrupts or intrudes on others (butts into conversations, games, etc.)				

Circle the setting(s) where these problems occur: Home Work/School Social settings / Community

Please comment on when these problems began and whether they are getting better or worse:

Depressive Symptoms

No Concerns: _____

If you show a consistently stable mood, with no more than expected levels of sadness or frustration in response to upsetting events and are able to “bounce back,” please check “No Concerns” above and skip to the next section.

Otherwise, please rate the following items:

	Never	Not a problem	Minor concern	Major concern
Depressed mood, most of the day, nearly every day, for at least two weeks				
Irritable mood most of the day, nearly every day, for at least two weeks				
Highly variable and unpredictable mood, nearly every day, for at least two weeks				
Has quit activities that used to be fun, or quit involvement in extra-curricular activities or sports that he / she used to value highly				
No longer pursues hobbies or leisure activities that he/she used to enjoy				
Appetite disturbance, such as poor appetite with weight loss or increased appetite with weight gain				
Sleep disturbance, such as not getting enough sleep or sleeping too much				
Complains of low energy and fatigue				
Feel like I have no friends, feel rejected by others				
Low self-esteem; feel like a failure				
Blame self for things that are not my fault				
Shows difficulty making decisions, poor concentration				
Spends too much time alone				
Talks about suicide or death				
Has made suicide gestures or left suicide notes				

Please comment on when these problems began and whether they are getting better or worse:

Symptoms of Mania or Bipolar Disorder

No Concerns _____

If you have never experienced a period of time lasting a week or more when you felt overly euphoric, neglected sleep without getting tired, and engaged in exciting but risky behaviors, please check “No Concerns” above and skip to the next section.

Otherwise, please rate the following items regarding a period when you did show those behaviors:

During a period, lasting at least a week, I have experienced the following:	Not very true	A little true	Very true	Extremely true
Showed inflated sense of self-esteem; saw self as more talented or more important than I probably was; grandiosity				
Stayed awake the entire night because of high energy level without feeling sleepy the next day				
Excessive talking, when it was hard for me to stop				
Racing thoughts or a flight of ideas that I can hardly keep up with				
More distractible than usual. Harder to stay focused on any one thing				
Had “big ideas” – started big projects, or more projects than nobody could probably complete – unrealistic plans				
Took excessive risks; thrill-seeking behavior				
Poor judgment regarding finances or sexual activity				
Extreme mood swings with cycles of highs and lows				
Angry outbursts in which I lost control or was unable to listen to reason				
Extreme giddiness or silliness (i.e., uncontrolled laughing) that lasted longer than normal				
Seemed elated or overly happy (almost as if on drugs) for no apparent reason				

Circle the setting(s) where these problems occurred: Home Work/School Social settings / Community

Please comment on when these problems began and whether they are getting better or worse:

Sensory Integration Problems

No Concerns _____

If you are aware of but are not extra sensitive to sounds, lights, or textures, and if you do not engage in overly repetitive movements, please check the blank above and skip to the next section.

Otherwise, please rate the following items.

	Never	Used to	A little	A lot
Strong reaction to textures (sand, paste, clothing, etc.), positive or negative				
Little awareness of pain or temperature				
Rejects certain food textures				
Bothered by certain sounds (refrigerator, vacuum cleaner, etc.)				
Seems unaware of sounds when he/she should notice them				
Bothered by light				
Fascinated with lights, fans, or water				
Avoids eye contact				
Very aware of smells				
Rocks body back and forth while sitting				
Likes spinning or swinging to an unusual degree				
Fearful of being on a swing, see-saw, or a high place				
Flaps hands, barks, or squeals when excited				
Walks on tip-toes				
Coordination problems				
Difficulty with transitions (doesn't "go with the flow")				
Becomes overwhelmed in crowded places or noisy settings				

Circle the setting(s) where these problems occur: Home Work/School Social settings / Community

Please comment on when these problems began and whether they are getting better or worse:

Signs of Being "Out of Touch with Reality"

No Concerns _____

If you have never shown signs of losing touch with reality, and have never experienced auditory or visual hallucinations, please check "No Concerns" above and skip to the next section.

Otherwise, please rate the following items:

	Never	Minor concern	Major concern
Seeing people who aren't there, ghosts, imaginary beings, etc.			
Hearing "voices" that others don't hear or when no one else is around			
Having ideas that others think are odd or bizarre			
Afraid of my own thoughts			
Sometimes feel as if bad people are spying on or following me			
Artwork or stories are gruesome or bizarre			

Circle the setting(s) where these problems occur: Home Work/School Social settings / Community

Please comment on when these problems began and whether they are getting better or worse:

Problems with Authority, Rebelliousness, Defiance No Concerns _____

If you generally follow rules with minimal fuss, please check “No Concerns” above and skip to the next section.

Otherwise, please rate the following items:

	Never/ Rarely	Some- times	Often	Very Often
Loses temper				
Touchy or easily annoyed				
Angry and resentful				
Argues with authority figures				
Actively defies or refuses to comply with rules				
Annoys others on purpose				
Blames others for my own mistakes or wrongful behavior				
Has been spiteful or vindictive at least twice in the past 6 months				
	<i>Yes</i>	<i>No</i>		

Circle the setting(s) where these problems occur: Home Work/School Social settings / Community

Please comment on when these problems began and whether they are getting better or worse:

Cigarettes, Drugs, or Alcohol No Concerns _____

If you have no concerns regarding cigarettes, drugs, or alcohol, please check “No Concerns” above and skip to the next section.

Otherwise, please rate the following items:

	Never	Sometimes, but it is not a problem	Possibly more than I should	Definitely more than I should
Smokes cigarettes				
Drinks beer or wine				
Drinks hard liquor				
Uses marijuana				
Uses cocaine				
Uses methamphetamines				
Uses club drugs				
Sniffs glue, gasoline, or other chemicals				
Has drug paraphernalia				
Has used or given away alcohol belonging to parents				
Steals money from family members for drugs/alcohol				

Dangerous, Destructive, or Illegal Behaviors

No Concerns _____

If you consistently obeys rules and laws, are generally mindful of the rights of other people, and respects the property and privacy of others, please check “No Concerns” above and skip this section.

Otherwise, please rate the following items:

	Never	Once or twice	Several times	It has become a pattern.
Bullies, threatens, or intimidates others				
Initiates physical fights				
Used a weapon that can cause serious harm to others (e.g., bat, bottle, gun)				
Has been physically cruel to people				
Has been physically cruel to animals				
Stealing while confronting a victim (e.g. Purse snatching, threatening)				
Forced someone into sexual activity				
Engaged in fire setting, intending to cause damage				
Deliberately destroyed others' property (outside the family)				
Broken into someone's house, building, car, or locker				
Lies to obtain goods or favors or to avoid obligations (“cons” others)				
Stolen items of value without confrontation (e.g. shoplifting, forgery)				
Stays home from work or school without being ill				

Circle the setting(s) where these problems occur: Home Work/School Social settings / Community

Please comment on when these problems began, and whether they are getting better or worse:

Are you currently on probation or facing legal charges? Yes No
 If “Yes”, please explain:

Have you been arrested or faced charges in the past? Yes No
 If “Yes”, please explain:

Sexuality and Sexual Issues

No Concerns _____

If you are content with your gender, wear clothes common to your gender, and showed average development of sexual interest, please check “No Concerns” above and skip to the next section.

Otherwise, please rate the following items:

	Never	A little	A lot
I feel I was born the wrong sex			
Wears clothes meant for the opposite sex			
Prefers activities usually considered typical of the opposite sex			
Chooses friends of the opposite sex almost exclusively			
Preoccupied with or interested in sexual matters			
Masturbates excessively			
sexually abused			
Unusually fast or early sexual development			

Concerns about sexuality not mentioned:

Circle the setting(s) where these problems occur: Home Work/School Social settings / Community

Please comment on when these problems began, and whether they are getting better or worse:

Other:

If this inventory has not addressed a concern you have, please describe:

Questionnaire Fatigue

If you are the type of person who is glad to reach the end of this inventory, please check this blank _____ 😊

Your time and thoughtful attention in providing this information is appreciated!