A*B*TA Problem Check List ~ (PCL)

Name______________________________ SSN_____-_____-________ Date________________________

List current medications (if none check here [ ] ____

Please indicate which of the following applies to you or a member of your family. If one applies to you tell us if it affects you recently or in the past. If it applies to a member of your family please indicate relationship (i.e. Mother, Father, Sister, Brother, Uncle etc. No names please). Thank you.

	Recent	Past	Relation		Recent	Past	Relation
Allergies.				**Alcohol or drug use/abuse?**			
Arthritis.				**Have you ever felt you ought**			
Asthma.				**to cut down on your drinking?**			
Blackouts/Dizziness.				**Have people Annoyed you by**			
Blurred vision.				**criticizing your drinking?**			
Cancer.				**Have you ever felt bad or**			
Circulatory problems.				**guilty about your drinking?**			
Colitis.				**Have you ever had a drink**			
Diabetes.				**first thing in the morning to**			
Emphysema.				**Steady your nerves or get rid**			
Female problems.				**Of a hang over? (Eye-opener)**			
Headaches.				**Anxiety - Excessive Worrying**			
Hearing difficulties.				**Afraid of things that are not**			
High blood pressure.				**feared by most people.**			
HIV Positive.				**Panic attacks.**			
Memory is worse.				**Bad Habits**			
Numbness (where).				**Feel uncomfortable**			
Chronic Pain				**Mood swings.**			
Scoliosis.				**Depression/Moodiness.**			
Seizures.				**Appetite or weight changes.**			
Smoke--How much?				**Sleep problems.**			
Stomach pain/distress.				**Reduced Energy or unusual Tiredness**			
Stroke or Heart Attack.				**Can't concentrate or focus as well.**			
Thyroid problems.				**Difficulty making decisions.**			
Ulcers.				**Restlessness, fidgety, or Lethargy.**			
Vision problems.				**Guilt or Worthlessness.**			
Back Injury.				**Reduced fun, pleasure or interests.**			
Car Wreck or Physical Injuries				**Loss of interest in sex.**			
Head injury.				**Suicidal thoughts or acts.**			
Unusual Family Background.				**Thoughts of violence or killing others.**			
Child of Alcoholic.				**Voices sometimes talk to me**			
Problems in relationships.				**when no one else is around.**			
Marriage problems.				**See things others do not see.**			
Children will not behave.				**Others are out to get or hurt me.**			
Abandonment issues.				**Stressed Out!!**			
Child, Sex, or Spousal abuse.				**Compulsive Behaviors.**			
Worried about Violence.				**Obsessive Thoughts.**			
Combat Veteran.				**Lack of Confidence.**			
I am or may be Gay/Lesbian.				**Nervous Breakdown.**			
Traumatized or Tortured				**I am uncomfortable with men.**			
Arrests or Convictions				**Phobias.**			
Legal or Financial problems				**Unreasonable Fears**			

Allergies (Medications/Food & Reactions): [if none check here [ ] ____

Hospitalizations:

date__________________ why?____ did you have surgery?__________

date__________________ why?____ did you have surgery?__________

If you checked any of the above, please give additional information.____