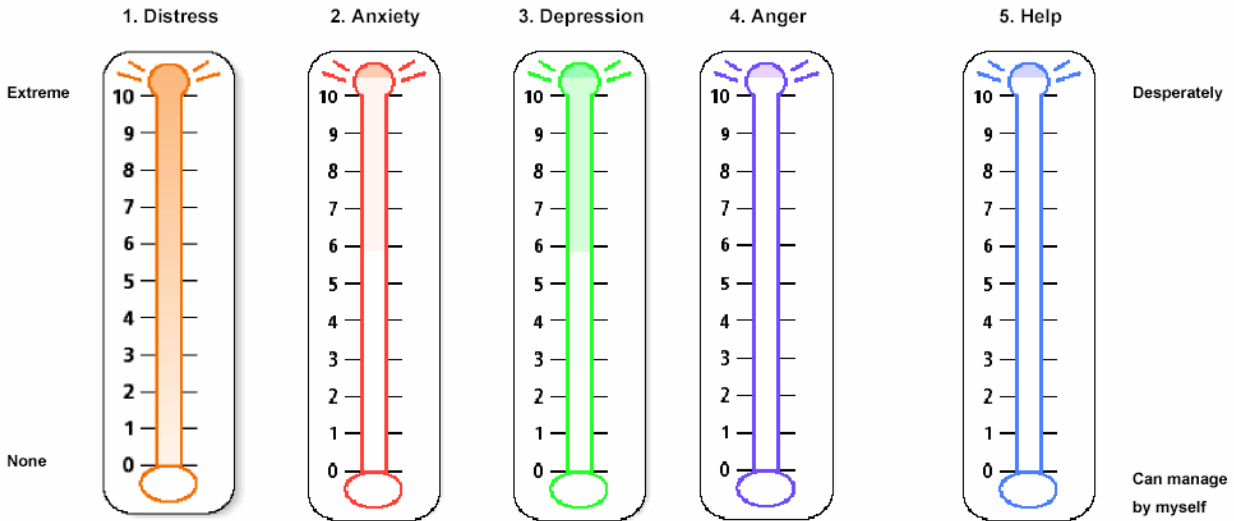


In the first four columns, please circle the number that best describes how much emotional upset you have been experiencing in the past week, including today. In the last column please indicate how much you need help for these concerns

Study No. _____

Date. _____



Please indicate if any of the following has been a cause of distress in the past week, including today. Be sure to check NO or YES for each.

NO	YES		NO	YES	
		Practical Problems			Physical Problems
<input type="checkbox"/>	<input type="checkbox"/>	Housing	<input type="checkbox"/>	<input type="checkbox"/>	Pain
<input type="checkbox"/>	<input type="checkbox"/>	Insurance	<input type="checkbox"/>	<input type="checkbox"/>	Nausea
<input type="checkbox"/>	<input type="checkbox"/>	Work/school	<input type="checkbox"/>	<input type="checkbox"/>	Fatigue
<input type="checkbox"/>	<input type="checkbox"/>	Transportation	<input type="checkbox"/>	<input type="checkbox"/>	Sleep
<input type="checkbox"/>	<input type="checkbox"/>	Child care	<input type="checkbox"/>	<input type="checkbox"/>	Getting around
		Family Problems	<input type="checkbox"/>	<input type="checkbox"/>	Bathing/dressing
<input type="checkbox"/>	<input type="checkbox"/>	Dealing with partner	<input type="checkbox"/>	<input type="checkbox"/>	Breathing
<input type="checkbox"/>	<input type="checkbox"/>	Dealing with children	<input type="checkbox"/>	<input type="checkbox"/>	Mouth sores
		Emotional Problems	<input type="checkbox"/>	<input type="checkbox"/>	Eating
<input type="checkbox"/>	<input type="checkbox"/>	Worry	<input type="checkbox"/>	<input type="checkbox"/>	Indigestion
<input type="checkbox"/>	<input type="checkbox"/>	Fears	<input type="checkbox"/>	<input type="checkbox"/>	Constipation
<input type="checkbox"/>	<input type="checkbox"/>	Sadness	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea
<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Changes in urination
<input type="checkbox"/>	<input type="checkbox"/>	Nervousness	<input type="checkbox"/>	<input type="checkbox"/>	Fevers
		Spiritual/Religious Concerns	<input type="checkbox"/>	<input type="checkbox"/>	Skin dry/itchy
<input type="checkbox"/>	<input type="checkbox"/>	Relating to God	<input type="checkbox"/>	<input type="checkbox"/>	Nose dry/congested
<input type="checkbox"/>	<input type="checkbox"/>	Loss of faith	<input type="checkbox"/>	<input type="checkbox"/>	Tingling in hands/feet
					Feeling swollen
					Sexual

Other Problems: _____

