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BEHAVIOR AND SYMPTOM IDENTIFICATION SCALE

Name _____ Date _____

Below is a list of problems and areas of life functioning in which some people experience difficulties. Using the scale below, WRITE IN THE BOX THE NUMBER that best describes THE AMOUNT OF DIFFICULTY YOU HAVE BEEN EXPERIENCING IN EACH AREA DURING THE PAST FEW WEEKS.

0 = No Difficulty 1 = A Little 2 = Moderate 3 = Quite a Bit 4 = Extreme

Please respond to each item. Do not leave any blank. If there is an area that doesn't seem to apply to you, mark is as No Difficulty with a 0.

TO WHAT EXTENT ARE YOU EXPERIENCING DIFFICULTY IN THE AREA OF:

1. MANAGING DAY-TO-DAY LIFE (e.g., getting places on time, handling money, ----- c
making everyday decisions)
2. HOUSEHOLD RESPONSIBILITIES (e.g., shopping, cooking, laundry, keeping ----- c
room or house clean, other chores)
3. WORK (e.g., completing tasks, performance level, finding/keeping a job) ----- c
4. SCHOOL (e.g., academic performance, completing assignments, attendance) ----- c
5. LEISURE TIME OR RECREATIONAL ACTIVITIES ----- c
6. ADJUSTING TO MAJOR LIFE STRESSORS (e.g., separation, divorce, moving, ----- b
new job, new school, the death of a significant other)
7. RELATIONSHIPS WITH FAMILY MEMBERS ----- a
8. GETTING ALONG WITH PEOPLE OUTSIDE OF THE FAMILY (e.g., friends, ----- a
co-workers)
9. ISOLATION OR FEELINGS OF LONELINESS ----- b
10. BEING ABLE TO FEEL CLOSE TO OTHERS ----- a
11. BEING REALISTIC ABOUT YOURSELF OR OTHERS ----- a
12. RECOGNIZING AND EXPRESSING EMOTIONS APPROPRIATELY ----- a

Behavior and Symptom Identification Scale

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TO WHAT EXTENT ARE YOU EXPERIENCING DIFFICULTY IN THE AREA OF:

- 13. DEVELOPING INDEPENDENCE, AUTONOMY ----- c
- 14. GOALS OR DIRECTION IN LIFE ----- a
- 15. LACK OF SELF-CONFIDENCE, FEELING BAD ABOUT YOURSELF ----- a
- 16. APATHY, LACK OF INTEREST IN THINGS (e.g., feeling unmotivated, ----- c
don't seem to care about things)
- 17. DEPRESSION, HOPELESSNESS ----- b
- 18. SUICIDAL FEELINGS OR BEHAVIORS (thinking about, planning, or ----- b
making suicidal gestures)
- 19. PHYSICAL SYMPTOMS (e.g., headaches, aches and pains, sleep problems, ----- b
stomachaches, dizziness)
- 20. FEAR, ANXIETY, OR PANIC ----- b
- 21. CONFUSION, CONCENTRATION, MEMORY PROBLEMS ----- c
- 22. DISTURBING OR UNREAL THOUGHTS OR BELIEFS ----- e
- 23. HEARING VOICES, SEEING THINGS ----- e
- 24. HYPER, UNUSUAL BEHAVIOR (e.g., periods of intense energy, racing thoughts, ----- e
excessive desire to do things such as clean or buy things, decreased need for
sleep, behavior which others would consider very unusual or inappropriate)
- 25. MOOD SWINGS, UNSTABLE MOODS (e.g., rapid or intense changes in mood, ----- d
feeling happy one minute and sad the next; frequent emotional ups and downs)
- 26. UNCONTROLLABLE, COMPULSIVE BEHAVIOR (e.g., excessive or unusual ----- d
eating, hand washing, intense need to repeat certain behaviors, hurting yourself)
SPECIFY problem behavior _____
- 27. SEXUAL ACTIVITY OR PREOCCUPATION (any sexual issue which is ----- e
problematic)

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TO WHAT EXTENT ARE YOU EXPERIENCING DIFFICULTY IN THE AREA OF:

28. DRINKING ALCOHOLIC BEVERAGES (problems with amount or urges to drink)----- d
29. TAKING ILLEGAL DRUGS, MISUSING DRUGS (use of illegal drugs; ----- d
misuse or overuse of prescribed medications)
30. CONTROLLING TEMPER, OUTBURSTS OF ANGER, VIOLENCE ----- d
31. IMPULSIVE, ILLEGAL, OR RECKLESS BEHAVIOR ----- d
32. FEELING SATISFACTION WITH YOUR LIFE (happy with what you are doing, ----- c
general sense of well-being)
-
-

a _____ - _____ T.S. _____ M

b _____ - _____ T.S. _____ M

c. _____ (_____) _____ - _____ T.S. _____ M

d _____ - _____ T.S. _____ M

e _____ - _____ T.S. _____ M

_____ B.T.S. _____ M.B.S.

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