

Symptom Checklist

Your initials _____ Date _____

Please check any of the following feelings, symptoms or situations that apply to you.

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|---|--|--|--|
| <input type="checkbox"/> Depressed | <input type="checkbox"/> Headaches | <input type="checkbox"/> Irritability | <input type="checkbox"/> Break laws |
| <input type="checkbox"/> Feel inferior | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Feel panicky | <input type="checkbox"/> Feel empty |
| <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Tremors | <input type="checkbox"/> Hear voices |
| <input type="checkbox"/> Sexual problems | <input type="checkbox"/> Racing heart | <input type="checkbox"/> Over-ambitious | <input type="checkbox"/> Food purging |
| <input type="checkbox"/> Poor concentration | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Shy | <input type="checkbox"/> Emotionless |
| <input type="checkbox"/> Suicidal thoughts | <input type="checkbox"/> Choking sensations | <input type="checkbox"/> Lonely | <input type="checkbox"/> Feel helpless |
| <input type="checkbox"/> Food bingeing | <input type="checkbox"/> Feeling anxious | <input type="checkbox"/> Money problems | <input type="checkbox"/> Avoid food |
| <input type="checkbox"/> Feel detached | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Work stress | <input type="checkbox"/> Low energy |
| <input type="checkbox"/> Guilt | <input type="checkbox"/> Nausea | <input type="checkbox"/> Legal problems | <input type="checkbox"/> Mood swings |
| <input type="checkbox"/> Crying spells | <input type="checkbox"/> Stomach trouble | <input type="checkbox"/> Easily distracted | <input type="checkbox"/> Unable to relax |
| <input type="checkbox"/> Poor memory | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Disorganized | <input type="checkbox"/> Alcohol use |
| <input type="checkbox"/> Drug use | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Lose items | <input type="checkbox"/> Anger, temper |
| <input type="checkbox"/> See no future | <input type="checkbox"/> Muscle tension | <input type="checkbox"/> Impatient | |

- | | | |
|---|--|--|
| <input type="checkbox"/> Are perfectionistic | <input type="checkbox"/> Difficulty keeping jobs | <input type="checkbox"/> Tried to harm or kill self |
| <input type="checkbox"/> Tend to be dramatic | <input type="checkbox"/> Make careless mistakes | <input type="checkbox"/> See things others do not |
| <input type="checkbox"/> Unable to enjoy self | <input type="checkbox"/> Feel life has no meaning | <input type="checkbox"/> Difficulty keeping friends |
| <input type="checkbox"/> Bad home conditions | <input type="checkbox"/> Difficulty remaining still | <input type="checkbox"/> Difficulty waiting in lines |
| <input type="checkbox"/> Purposely try to hurt others | <input type="checkbox"/> Difficulty making decisions | |
| <input type="checkbox"/> Feel afraid of your emotions | <input type="checkbox"/> Difficulty finishing projects | |

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|--|---|
| <input type="checkbox"/> Lack of interest in doing things | <input type="checkbox"/> Difficulty with romantic relations |
| <input type="checkbox"/> Purposely cut or hurt your body | <input type="checkbox"/> Feel as if people will abandon you |
| <input type="checkbox"/> Afraid others are out to get you | <input type="checkbox"/> Less interested in pleasant activities |
| <input type="checkbox"/> Like to be the center of attention | <input type="checkbox"/> Always need to be in a relationship |
| <input type="checkbox"/> Perceive self as ugly or deformed | <input type="checkbox"/> Constantly on guard for anything dangerous to happen |
| <input type="checkbox"/> Try to get away with petty crimes | <input type="checkbox"/> Constantly need assurance from others |
| <input type="checkbox"/> Use other people as a means to get your desires met | <input type="checkbox"/> Abuse—Emotional, Physical, Sexual (circle which) |

With regard to your sleep, do you...

- | | | |
|-----|----|-----------------------------------|
| Yes | No | Have difficulty falling asleep? |
| Yes | No | Have difficulty waking up? |
| Yes | No | Frequently wake during the night? |
| Yes | No | Sleep really long periods? |
| Yes | No | Wake earlier than intended? |

In the past month have you...

- | | | |
|-----|----|--------------------------------|
| Yes | No | Gained weight? |
| Yes | No | Lost weight? |
| Yes | No | Had poor appetite? |
| Yes | No | Noticed an increased appetite? |

Do you experience fear of...

- | | | |
|-----|----|--|
| Yes | No | Losing control? |
| Yes | No | Going "crazy"? |
| Yes | No | Dying? |
| Yes | No | Crowded places? |
| Yes | No | Social situations? |
| Yes | No | Another specific situation, animal, thing?
(please specify _____) |

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|-----|----|---|
| Yes | No | Do you ever have unwanted repetitive thoughts? |
| Yes | No | Do you ever perform unwanted repetitive habits? |
| Yes | No | Have periods of time when you feel as if "driven by a motor"? |
| Yes | No | Have periods of time when you feel "on top of the world"? |
| Yes | No | Have periods of time when you read several books at a time? |
| Yes | No | Have periods of time when you feel you can accomplish anything? |
| Yes | No | Have periods of time when you go on spending sprees? |
| Yes | No | Have periods of time when you drive at high speeds? |

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|-----|----|---|
| Yes | No | Have you ever witnessed a life threatening event or serious injury? |
| Yes | No | Have you ever been in an unusually stressful situation such as a war, disaster, or assault? |

If YES to either of the above, did you...

- | | | |
|-----|----|--|
| Yes | No | Experience fear during the event? |
| Yes | No | Experience hopelessness or horror during the event? |
| Yes | No | Do you now ever experience distressing recollections of the event? |
| Yes | No | Do you now ever experience distressing dreams of the event? |
| Yes | No | Do you now ever act or feel as if the event was recurring? |
| Yes | No | Do you now have difficulty talking about the event? |
| Yes | No | Do you now have difficulty seeing anything that reminds you about the event? |

I am taking
the following
Psychotropic medication(s)

