SYMPTOM CHECKLIST

Name: ______________________

Please mark the severity of any current or recent symptoms.

absent = 0 (or leave blank) **mild = 1** **moderate = 2** **severe = 3** don't know = ?

ON INTAKE, COMPLETE THE LEFT HAND (SQUARES) COLUMNS

DATE	____	____	____
Headache	□	○	◇
Shortness of breath	□	○	◇
Dizziness	□	○	◇
Feeling faint	□	○	◇
Trembling	□	○	◇
Shaking	□	○	◇
Sweating	□	○	◇
Heart pounding	□	○	◇
Rapid heartbeat	□	○	◇
Chest pain	□	○	◇
Nausea	□	○	◇
Constipation	□	○	◇
Diarrhea	□	○	◇
Poor appetite$_3^1$	□	○	◇
Weight loss$_3$	□	○	◇
Weight gain	□	○	◇
Nervousness	□	○	◇
Fearful for no reason	□	○	◇
Feeling panic	□	○	◇
Phobias	□	○	◇
Unpleasant dreams	□	○	◇
Missing blocks of time	□	○	◇
Impaired memory	□	○	◇
Feeling unreal	□	○	◇

DATE	____	____	____
Difficulty making friends	□	○	◇
Difficulty making decisions$_8$	□	○	◇
Having unreasonable anger	□	○	◇
Poor impulse control	□	○	◇
Feeling too energetic	□	○	◇
Poor judgment	□	○	◇
Low self-esteem[4]	□	○	◇
Depressed mood$_1^A$	□	○	◇
Feeling hopeless[6]	□	○	◇
Feeling worthless$_7$	□	○	◇
Feeling guilty$_7$	□	○	◇
Feeling tired$_6$	□	○	◇
Loss of energy$_6^3$	□	○	◇
Loss of interest or pleasure$_2$	□	○	◇
Poor concentration$_8^5$	□	○	◇
Sexual dysfunction	□	○	◇
Feel life is not worth living	□	○	◇
Thoughts of dying$_9$	□	○	◇
Thoughts of hurting self$_9$	□	○	◇
Thoughts of hurting others	□	○	◇
Sleep problems$_4^2$ ____________	□	○	◇
Alcohol/drug problems ________	□	○	◇
Eating problems$_3^1$ ____________	□	○	◇
Other ____________________	□	○	◇