



Symptom Checklist for ADULTS



Please note that the responses you provide here are protected as confidential information.

Name: _____ Date: _____

Home Phone

Cell

Date of birth: _____ Age: _____ Male _____ Female _____

Check any of the following symptoms that you are currently experiencing or have experienced in the past 6 months.

SYMPTOMS:

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This column office use only

<u>Currently</u> ----- <u>OR</u> ----- <u>Past 6 mo.</u>	F	I	<u>Currently</u> ----- <u>OR</u> ----- <u>Past 6 mo.</u>	F	I
Extreme anxiety	/	/	Alcohol use	/	/
Panic attacks	/	/	DUI	/	/
Extreme depressed mood	/	/	Recreational drug use	/	/
No interest in fun activities	/	/	Pornography	/	/
Fatigue/lack of energy	/	/	Gambling problem	/	/
Loss of appetite/overeating	/	/	Eating disorder	/	/
Trouble sleeping	/	/	Marital problems	/	/
Poor concentration	/	/	Other relational problems	/	/
Feeling worthless	/	/	Child custody issues	/	/
Recent death in family	/	/	Physical abuse	/	/
Grief	/	/	Sexual abuse	/	/
Self injury	/	/	Verbal abuse	/	/
Nightmares	/	/	Emotional abuse	/	/
Unwanted memories	/	/	Gender confusion	/	/
<i>Unexplained</i> losses of time	/	/	Loneliness	/	/
<i>Unexplained</i> memory lapses	/	/	Shyness	/	/
Frequent body complaints	/	/	Low self-esteem	/	/
Suicidal thoughts	/	/	Body image problems	/	/
Attempted suicide	/	/	Fears	/	/
Anger problem	/	/	Phobias	/	/
Hostility	/	/	Pregnancy	/	/
Homicidal thoughts	/	/	Abortion	/	/
Domestic violence	/	/	Work stress	/	/
Loss of control	/	/	Career choices	/	/
Rapid mood swings	/	/	Indecisiveness	/	/
Obsessive thoughts	/	/	Parenting problems	/	/
Compulsive behaviors	/	/	Financial problems	/	/
Hallucinations (see things others don't see)	/	/	Sexual problems	/	/
Hearing voices	/	/	Spiritual questioning	/	/
Controlled by others	/	/	Other _____	/	/
Racing thoughts	/	/	_____	/	/
	/	/	_____	/	/

PAPERWORK SHREDDED AFTER 90 DAYS IF NO APPOINTMENT IS MADE FOR COUNSELING.

Below this line is for office use only



**Columns: F = Frequency (D=Day W=Week M=Month)
I = Intensity Rating Scale 1 to 10 (high)**