

SYMPTOM CHECKLIST

Date: _____

Name: _____

- | | |
|--|---|
| <input type="checkbox"/> Angry or irritable feelings | <input type="checkbox"/> Sleep difficulties |
| <input type="checkbox"/> Loss of Interest | <input type="checkbox"/> Impulses to hurt self or others |
| <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Nightmares |
| <input type="checkbox"/> Crying spells | <input type="checkbox"/> Feeling that nothing mattered |
| <input type="checkbox"/> Difficulty making decisions | <input type="checkbox"/> Anxiety or nervousness |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Violent behavior |
| <input type="checkbox"/> Suicidal thoughts | <input type="checkbox"/> Memory loss |
| | |
| <input type="checkbox"/> Panicky feelings | <input type="checkbox"/> Disorientation |
| <input type="checkbox"/> Fears of particular situations | <input type="checkbox"/> Obsessive preoccupations |
| <input type="checkbox"/> Avoidance of social situations | <input type="checkbox"/> Repeated thoughts |
| <input type="checkbox"/> Weakness | <input type="checkbox"/> Compulsive behaviors |
| <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Easily distracted |
| <input type="checkbox"/> Mood swings | <input type="checkbox"/> Feel that you may lose control |
| | |
| <input type="checkbox"/> Paranoid feelings | <input type="checkbox"/> Visual or auditory hallucinations |
| <input type="checkbox"/> Elevated mood or euphoria | <input type="checkbox"/> Confusion |
| <input type="checkbox"/> Too much energy | <input type="checkbox"/> Disorganized thoughts |
| <input type="checkbox"/> Can't stop talking | <input type="checkbox"/> Self-critical |
| <input type="checkbox"/> Racing thoughts | <input type="checkbox"/> Feel more important than others |
| <input type="checkbox"/> Inability to talk | <input type="checkbox"/> Hear voices when no one is there |
| <input type="checkbox"/> Suspiciousness | <input type="checkbox"/> See things that aren't there |
| <input type="checkbox"/> Believe your thoughts are controlled | <input type="checkbox"/> Transmit your thoughts to others without speaking |
| <input type="checkbox"/> Believe there are plots against you | <input type="checkbox"/> Hear your thoughts out loud |
| <input type="checkbox"/> Fear others | |
| | |
| <input type="checkbox"/> Difficulty following rules | <input type="checkbox"/> Difficulty trusting others |
| <input type="checkbox"/> Difficulty feeling warm to others | <input type="checkbox"/> Not getting along with people |
| <input type="checkbox"/> Wanting or letting everyone do things for you | <input type="checkbox"/> Trying to be perfect |
| <input type="checkbox"/> Avoiding responsibilities | <input type="checkbox"/> Being overly sensitive |
| <input type="checkbox"/> Selfishness | <input type="checkbox"/> Use others for personal gain |
| | |
| <input type="checkbox"/> Nausea/vomiting | <input type="checkbox"/> Exaggerating physical problems |
| <input type="checkbox"/> Excessive concern over a physical problem | <input type="checkbox"/> Exaggerating emotional problems |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Recent weight gain; how much _____ |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Recent weight loss; how much _____ |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Lack of energy |
| <input type="checkbox"/> Medical problems _____ | <input type="checkbox"/> Use of alcohol |
| <input type="checkbox"/> Drug use or addiction | <input type="checkbox"/> Bulimia (gorging then vomiting) |
| <input type="checkbox"/> Anorexia (not eating) | <input type="checkbox"/> Physically abusing yourself |
| <input type="checkbox"/> Cheating or stealing | |

WHAT RESULTS YOU WOULD LIKE TO HAVE FROM YOUR THERAPY

COUPLE RELATIONSHIP

- Tension
- Arguments
- Emotional distance
- Communications problems

- Alcohol or other addiction problems
- Stresses from health problems
- No couple relationship; which is ___ is not ___ a problem.

EXTENDED FAMILY

- Recent losses
- On-going difficult interactions with

WORK OR SCHOOL RELATED

- Upsetting interactions
- Financial insecurity

COMMUNITY RELATED

- Insufficient friendships
- Over-extended; friends/work
- No support system

- Tension in friendships
- Tension with others

CHILDREN

Names Ages

- Tension
- Angry exchanges
- Problems in relationships with siblings
- Children exhibiting behavioral problems
- Health Problems
- No children, which is ___, is not ___ a problem