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Name _____ Date _____

Age: _____ Marital Status: _____ Employment Status: _____

Date Symptoms Began: _____ Date Symptoms Worsened: _____

What is your goal for seeking Counseling at this time in your life? _____

SYMPTOM CHECKLIST

- | | | |
|---|--|--|
| <input type="checkbox"/> Depressed or Sad Mood | <input type="checkbox"/> Anxiety about everything | Suicidal thoughts? o Yes o No |
| <input type="checkbox"/> Irritability/Short tempered | <input type="checkbox"/> Intense episodes of fear | <input type="checkbox"/> passing thoughts/no intent |
| <input type="checkbox"/> Lack of Motivation/Drive | <input type="checkbox"/> Fear of Going crazy/losing control | <input type="checkbox"/> persistent thoughts |
| <input type="checkbox"/> Poor Concentration | <input type="checkbox"/> Chills/Hot flashes | <input type="checkbox"/> current plans/definite intent |
| <input type="checkbox"/> Can't sleep well | <input type="checkbox"/> Abdominal distress/nausea | <input type="checkbox"/> recent attempt |
| <input type="checkbox"/> Appetite/weight changes | <input type="checkbox"/> Chest discomfort/choking | <input type="checkbox"/> past attempts |
| <input type="checkbox"/> Loss of pleasure in activities | <input type="checkbox"/> Dizziness | |
| <input type="checkbox"/> Diminished self-esteem | <input type="checkbox"/> Numbness/tingling | <input type="checkbox"/> Pulling hair out |
| <input type="checkbox"/> Hopeless/Helpless | <input type="checkbox"/> Feeling jumpy/on edge/easily startled | <input type="checkbox"/> Anger/Emotional outburst |
| <input type="checkbox"/> Decreased Energy/fatigue | <input type="checkbox"/> Constantly Alert/Vigilant | <input type="checkbox"/> Binge Eating/Purging |
| <input type="checkbox"/> Excessive guilt or worry | <input type="checkbox"/> Nightmares/reliving trauma | <input type="checkbox"/> Uncontrolled Gambling |
| <input type="checkbox"/> Crying Spells | <input type="checkbox"/> Avoiding of stressors/stimulus | <input type="checkbox"/> Stealing or Lying |
| <input type="checkbox"/> Decreased sex drive | <input type="checkbox"/> Heart racing/palpitations | <input type="checkbox"/> Ritualized behaviors/obsessions |
| <input type="checkbox"/> Intense fear of being fat | <input type="checkbox"/> Sweating | |
| | <input type="checkbox"/> Trembling | <input type="checkbox"/> Attention/concentration issues |
| <input type="checkbox"/> Spending sprees | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Impulsive/can't wait turn |
| <input type="checkbox"/> Special Abilities | <input type="checkbox"/> "Lump in Throat"/can't swallow | <input type="checkbox"/> Hyperactive/restless |
| <input type="checkbox"/> Increased self-esteem | <input type="checkbox"/> Intense anxiety, fear, or panic | <input type="checkbox"/> Can't perform at work/school |
| <input type="checkbox"/> Decreased need for sleep | <input type="checkbox"/> Unable to leave home | <input type="checkbox"/> Aggressive/Assaultive |
| <input type="checkbox"/> Lots of great ideas to get out | | <input type="checkbox"/> Self-mutilation/Self-harm |
| <input type="checkbox"/> Racing thoughts/can't keep up | <input type="checkbox"/> Counts things constantly | <input type="checkbox"/> Sleeping all the time |
| <input type="checkbox"/> Increased energy/hyperactive | <input type="checkbox"/> Impaired intellect/thinking | <input type="checkbox"/> Staring spells |
| <input type="checkbox"/> Increased Sex Drive | <input type="checkbox"/> Language/speech difficulties | <input type="checkbox"/> Chronic Pain |
| <input type="checkbox"/> Making lots of plans/schemes | <input type="checkbox"/> Impulsive/poor judgment | <input type="checkbox"/> Self induced vomiting |
| <input type="checkbox"/> Rapid speech | <input type="checkbox"/> Unusual sleep pattern | <input type="checkbox"/> Constant agitation |
| <input type="checkbox"/> Nonstop talking/can't interrupt | <input type="checkbox"/> Disorganized/Confused | <input type="checkbox"/> Intense fear of ejection/ |
| <input type="checkbox"/> Day-to-Day mood swings | <input type="checkbox"/> Poor Memory | <input type="checkbox"/> Legal Troubles |
| | | <input type="checkbox"/> Unexplained body complaints |
| <input type="checkbox"/> Suspiciousness/Paranoia | | |
| <input type="checkbox"/> Hallucinations (see/hear things) | SUBSTANCE ABUSE | |
| <input type="checkbox"/> Unusual facial expressions | <input type="checkbox"/> Amphetamines/Stimulants | |
| <input type="checkbox"/> Strange posture/gestures | <input type="checkbox"/> Cocaine/Crack | |
| <input type="checkbox"/> Disorganized thoughts | <input type="checkbox"/> Marijuana/Cannabis | |
| <input type="checkbox"/> Confusion | <input type="checkbox"/> Alcohol | |
| <input type="checkbox"/> Bizarre Behaviors | <input type="checkbox"/> Sedative/Hypnotics | |
| <input type="checkbox"/> Unusual or unwanted thoughts | <input type="checkbox"/> Opiates/Narcotic pain pills/Heroin | |
| <input type="checkbox"/> Constantly washes hands | | |

Personal Past Psychiatric History: Counseling Psychiatrist Hospitalization Suicidal Attempts

Past or Current Medical Issues (thyroid/high blood pressure/etc) _____

Please List your top 3 symptoms: _____