SYMPTOM CHECKLIST

NAME_____ DATE_____

Please check off symptoms you've had this past week. If you've had them frequently in the past year, then check of "Past Year" column.

PAST WEEK	***SYMPTOM***	***PAST YEAR***
___	FEELING SAD	___
___	CRYING SPELLS	___
	(how many crying spells?)	
___	FEELING DEPRESSED	___
___	SUICIDAL THOUGHTS	___
___	ANXIETY	___
___	IRRITABILITY	___
___	TROUBLE SLEEPING	___
___	EATING TOO MUCH	___
___	NOT EATING	___
___	POOR CONCENTRATION	___
___	TIREDNESS/FATIGUE	___
___	PANIC ATTACKS	___
___	LOSS OF SEXUAL DESIRE	___
___	DEATH IN FAMILY	___
	(who? _____ when?_____ expected or not?___)	
___	FINANCIAL SETBACK	___
___	GAMBLING LOSSES >$300	___
___	BANKRUPTCY	___
___	JOB LOSS/CHANGE/STRESS	___
___	MAJOR ILLNESS/SURGERY	___
	(for?_____ when? _____	___
___	FLASHBACKS/NIGHTMARES	___
	(how often? _____/week)	