SYMPTOM CHECKLIST

NAME_____ DATE_____

The reason I am here today is:_____

Please check the items below which apply to you in the past six months:

____change in appetite
____loss of weight
____weight gain
____binge or purge
____worried about your weight
____trouble sleeping
____high energy
____low energy
____restless/difficulty sitting still
____anxious or nervous
____loss of interests
____feel like mind playing tricks
____irritable
____job loss or stress or change
____flashbacks or nightmares

____worried or anxious
____forgetfulness or memory problems
____angry outbursts: rarely seldom often
____verbal fighting
____physical fighting
____sexual problems (loss of desire/performance)
____difficulty concentrating
____racing thoughts
____sad or depressed
____crying spells: _____/day or _____/week
____thoughts of suicide
____self hurt/harm: cutting? ___Yes ___No
____recent death : who_____ yes/no expected?
____major illness surgery_____
____bankruptcy/financial setback

Have you ever had counseling or medication for any of the above?_____Yes_____No If "Yes," where_____when_____with whom_____

Have you been hospitalized for any of the above? __No. If yes,reason_____ If "Yes," where_____when_____what Dr._____

How do you describe your overall health: ___Excellent ___Good ___Fair ___Poor

Please complete the following chart:

Medication	Date Started	Daily Amount	Reason	

Do you gamble? ___Yes ___No How many times per month?____ How much do you spend per month to gamble? _____.

Do you view porn? ____ Yes ___No How many times per day____ / _____per week

Do you think your gambling or porn use adversely affects you?____Yes ____No

Your spouse/partner?____Yes ____No Or your family?____Yes ____No

Do you vape? ___Yes___ No How often? _____/day _____/week Do you smoke weed?_____

How many times per day____ / _____per week