SYMPTOM CHECKLIST

CLIENT'S Name:_____ Date:_____

Reason for seeking assessment/treatment: _____

_____

Please check any of the concerns or symptoms listed below that you are currently experiencing or have experienced in the last 3 to 6 months:

___ marriage/relationship problems
___ difficulties with family or relatives
___ difficulties with friends
___ school problems
___ work problems
___ divorce-adjustment issues
___ serious physical illness (self or family)
___ health concerns (self or family)
___ fatigue/low energy
___ death of family member, friend, pet
___ anxiety/worry/nervousness
___ panic attacks
___ reluctant to leave home/neighborhood
___ perfectionism
___ guilt/shame feelings
___ trouble sleeping
___ depressed mood/sadness
___ suicidal thoughts
___ self-injury
___ eating habits
___ spending habits
___ concerns about behavior/habits/compulsions
___ concern about alcohol/drug use
___ concern about lying or dishonesty
___ anger/irritability/temper-outbursts
___ mood swings
___ recent break-up in dating relationship
___ aggressive/violent behaviors
___ physical abuse of self (current or past)
___ verbal/emotional abuse (current or past)
___ loss of interest in previous activities
___ recurrent flashbacks
___ episodes of lost time, unexplainable actions
___ trouble with memory or concentration
___ confusion
___ much fantasy or daydreaming
___ hyperactivity/attention problems
___ headaches/stomach aches
___ sexual problems
___ sexual identity concerns
___ general identity concerns
___ feelings of unreality
___ obsessive thoughts/excessive fears
___ unusual thoughts or perceptions
___ excessive energy
___ impulsive decisions or actions
___ difficulty trusting others
___ low self-esteem
___ avoidance of conflict
___ withdrawn, isolating, shyness
___ addictive behaviors/patterns
___ excessive electronic/computer use
___ fear of disapproval; fear of failure
___ need to please others and be liked
___ difficulty saying "no" to others or asserting self
___ difficulty making independent decisions
___ feelings of futility/loss of hope
___ loss of joy in living
___ physical abuse of others
___ other _____

1. As the Client, please rate the overall level of stress that you feel is currently pressing upon you, as it relates to your day-to-day life (Circle appropriate number):

1	2	3	4	5
minimal		moderate		extreme

comment:

2. Please describe how your concerns or symptoms are interfering with:

a. your quality of life and inner well-being:

b. your relationships:

c. your work/school:

d. your health/ability to get exercise:

3. In thinking about your network of friends, family, etc., how would you rate the amount of helpful social support currently available to you:

1	2	3	4	5
none		some, but not adequate		adequate

4. As a result of therapy or assessment, what specific results or changes do you wish to see happen:

5. If you have had any previous counseling or therapy, please tell us what you found helpful and what you found not helpful: