Symptom Checklist

Name:_____ Date:_____

1. *Circle all of the following that apply to you.*

Muscle tension
Difficulty concentrating
Irritability
Easily fatigued
Loss of appetite
Increased appetite
Crying spells
Easily distracted
Weight gain
Indecisive
Fluctuating moods
Weight loss
Low self-confidence
Argumentative
Violent outbursts
Feeling sad/depressed
Lack of energy
Loss of interest in sex
Sleep too much
Difficulty falling asleep/staying asleep
Difficulty waking when necessary
Decreased desire to be with others
Decreased interest/enjoyment of activities
Racing thoughts
Change in memory
Self injury
Wanting to hurt yourself
Unwanted, intrusive thoughts
Compulsive "checking" or counting
Giddiness; elevated mood

Short intense periods of fear or discomfort with:

Panting/racing heart
Sweating
Shortness of breath
Choking/chest discomfort or pain
Nausea
Dizziness/unsteadiness/lightheadedness
Fear of losing control
Fear of dying
Numbness or tingling sensations
Chills, hot flashes

Compulsive behaviors such as:

- Spending
- Gambling
- Drinking or drug taking
- Eating/Bingeing
- Other_____

2. Any other thoughts, behaviors, or feelings of concern to you?

3. Overall, how would you rate the interference of the above factors in your life?

Mild Moderate Severe