Symptom Check List--Please print, fill out and bring to your first appointment

Date:_____

Name of identified patient:_____

Name of person filling in form:_____

Symptoms: Please check all those that apply

___ Depression
___ Anxiety
___ Worry
___ Anger
___ Irritability
___ Inability to concentrate
___ Confusion
___ Lack of pleasure
___ Compulsive behavior
___ Obsessive thoughts
___ Recurring dreams
___ Paranoia
___ Memory loss
___ Panic attacks
___ Sexual dysfunction
___ Loss of appetite
___ Loss of weight # of pounds_____
___ Increased appetite
___ Increase in weight, # of pounds_____

___ Crying a lot
___ Suicidal thoughts
___ Homicidal thoughts
___ Family problems
___ Sleep disturbances
___ Restlessness
___ Phobias
___ Low self-esteem
___ Feelings of hopelessness
___ Racing thoughts
___ Strange thoughts
___ Hearing voices
___ Insomnia
___ Slurred speech
___ Black outs
___ Fatigue
___ Non-Prescription Drug usage
___ Prescription Drug usage
___ Alcohol usage

Other:_____

Areas these symptoms effect: Please check all those that apply

___ Home
___ Marital
___ Parental
___ School
___ Occupational
___ Social
___ Medical (Physical)
___ Spiritual

Other:_____