Name: _____
Date: _____

SYMPTOM CHECK LIST

Please CHECK the symptoms that relate to you as currently connected to your seeking therapy.

Please CIRCLE the symptoms that have been of longer duration.

___Confusion
___Agitation
___Tension
___Feeling depressed
___Talking fast
___Feeling worthless
___Feeling guilty
___Fear of losing control
___Feeling inadequate
___Suicidal thoughts
___Suicidal acts
___Fear of going crazy
___Disturbed sleep
___Appetite changes
___Unusual body sensations
___Choking/Smothering
___Excitement
___High/Low Mood Swings
___Feeling hopeless
___Poor judgment
___Palpitations
___Feelings of unreality
___Trembling/shaking
___Tingling in hands/feet
___Hot and cold flashes
___Faintness
___Difficulty concentrating
___Exhaustion
___Social withdrawal
___Restlessness
___Loss of interests
___Incoherence
___More energy then usual
___Tearfulness
___Numbness
___Eye focus difficulty
___Fear of hurting people
___Hearing voices
___Poor attention

___Fear of being alone
___Suspicious
___Jealous
___Excessive worrying
___Can't reason things out
___Loss of daily functioning
___Self-critical
___Critical of others
___Dizziness
___Chest pain/discomfort
___Fear of dying
___Inability to relax
___Sweating
___Irritable
___Upset stomach
___Nausea
___Frequent urination
___Hypervigilant
___Distracted
___Anxious
___Diarrhea
___Constipation
___Lump in throat
___Recurrent thoughts/images
___Recurrent dreams
___Exaggerated startle response
___Poor memory recall
___Chronic tiredness
___More active or talkative
___Possessive
___Loss of ability to feel pleasure
___Less active or talkative
___Brooding about future/past
___Simple headaches
___Migraine headaches
___Elated
___Fear of being hurt by others
___Seeing things that aren't there
___Slurring or stuttering