Adult Symptom Checklist *Name* _____ *Date* _____

The value of collecting baseline clinical information is to understand your concerns, to develop an appropriate plan for our work together, and to assess progress toward your goals.

Please note here in your own words the reason for seeking psychological services today. If the reason has been long-standing, please state what happened recently that led you to come at this time.

_____

_____

Please read <u>both sides</u> of this sheet and check off all items that apply. Thank you.

___ I feel sad or depressed.
___ I have felt very depressed daily for at least 2 weeks.
___ I have had similar episodes during my lifetime.
___ I have felt depressed for over 2 years.
___ I feel worthless or guilty.
___ I feel hopeless and helpless.
___ I have lost interest in usual daily activities.
___ I keep thinking about death.
___ I have thoughts about harming myself.
___ I have been thinking about suicide.
___ I have a plan to commit suicide.
___ I have been very tearful.

___ I have experienced periods of unexplainable high energy, elation, and confidence when other people thought you were not your normal self.
___ I have been experiencing irritability, anger, impatience, or flaring temper.
___ My emotions have been shifting rapidly without adequate control, such as sudden bursts of crying, shouting, arguing, or starting fights.
___ My thoughts have been racing, and I can't slow my mind down.

___ It is hard for me to focus my attention.
___ I am easily distracted by things around me.
___ I am restless, have a lot of "nervous energy."
___ I am having trouble making decisions.
___ I have trouble staying organized and on track.
___ It is difficult for me to start and complete tasks.
___ I get bored easily.

___ I feel edgy, keyed up.
___ I feel intense anxiety.
___ I have been worried or anxious most of the time in the last six months.
___ I startle very easily.

___ I repeatedly experience thoughts, images, memories, nightmares, or flashbacks about a horrifying event.
___ Sometimes I feel like I am re-experiencing the event.
___ I tense up when I am reminded of the event.
___ Significant parts of the event are difficult for me to recall.
___ Usually I just do not want to talk about the event.
___ I avoid reminders of the event (for example, activities, places, feelings, or people who bring it to mind).
___ I feel detached, in a daze, as if things are not real.
___ Sometimes I feel numb when I think I should be feeling emotions.

___ I've experienced an abrupt episode of intense fear.
___ I have had several panic attacks.
___ I fear getting another panic attack.
___ I worry about being stuck someplace, and experiencing anxiety or panic.
___ In unfamiliar situations, I scan the environment around me for possible problems.
___ I worry about losing control, "going crazy," or having a heart attack.
___ I have become much more careful.
___ I worry about being away from my home alone.

___ I fear or avoid some social situations (for example, crowds).
___ I fear or avoid some performance situations (for example, speaking before groups).
___ I fear a specific activity or action (for example, driving the freeway).
___ I feel driven to do certain things over and over (for example, checking or counting things, repeating words silently, hand washing, hoarding, or exercise).
___ I have been engaging in excessive, impulsive, or risky behavior (for example, spending, gambling, eating, or sexual behavior).

___ I have been experiencing unexplainable altered perceptual states.
___ I have been experiencing unreal or strange thoughts.
___ I have been experiencing unusual sensations of taste, smell, or touch.
___ I have been hearing noises or voices when there is no one there.
___ I believe someone wants to hurt me.
___ I have been experiencing the impulse to hurt myself or other people.

___ I tend to be a person who characteristically:
___ Is inhibited or detached from social relationships.
___ Is dependent and needs lots of reassurance.
___ Is perfectionistic and compulsive about details.
___ Is admired but also envied by others.
___ Is dramatic and emotional.
___ Experiences intense interpersonal relationships.
___ Is cautious and mistrustful of others.
___ Other people would call unusual or eccentric.
___ Does not conform to social norms or expectations.

___ My energy is low nearly every day and I am easily fatigued.
___ I have noticed a change in my appetite.
___ I have noticed a weight change.
___ I have begun to move more slowly.
___ I have difficulty falling or staying asleep through the night.
___ I need a lot less sleep than usual.
___ I have been sleeping a lot more lately.

___ I have ongoing muscle tension.
___ I experience frequent trembling and shaking.
___ I experience frequent sweating.
___ I get chills or hot flashes.
___ My heart beat is rapid or pounding.
___ I feel shortness of breath or smothering sensations.
___ I feel like I am choking.
___ I get chest pains or discomfort.
___ I feel nausea or abdominal distress.
___ I feel dizzy, unsteady, lightheaded, or faint.
___ I experience frequent numbness or tingling sensations.
___ I have been having problems functioning sexually.

___ I have been having trouble remembering facts.
___ I have been forgetting to take care of myself (for example, locking the door, turning off the gas, or taking medications).
___ I have been getting lost and having trouble knowing where I am.

___ The following medical problems have bothered me in the last year (for example, chronic pain, seizures, lapses of consciousness, obesity, diabetes, thyroid condition, tics, hypertension, malignancy, or cardiac disease):

_____

_____

_____

__ My physician/psychiatrist has prescribed the following medications. (Please include dosages and how frequently you take each.):

_____

_____

_____

__ I sometimes help myself to feel better through using over-the-counter medications. Please list those medications:

_____

_____

_____

___ I sometimes help myself to feel better through drinking alcohol or using other recreational drugs. Please list what and how much you use on average per day:

_____

_____

_____

During the last year I have experienced:
___ Major change in work or school situation.
___ Major change in financial situation.
___ Major change in living situation or housing.
___ Major changes in family group or primary relationship.
___ Family conflict.
___ Chronic or disabling illness of family member.
___ Significant loss or rejection.
___ Exposure to disaster, either natural or man-made.
___ Legal problems.
___ Discrimination or harassment.
___ Victim or witness to crime.
___ Actual or threatened death or serious injury.
___ Unwanted pregnancy.

My present difficulties have been hindering me from being able to function in the following areas of life.
___ Job/school attendance.
___ Job/school performance.
___ Job/school relationships.
___ Marriage/intimate relationship.
___ Social relationships, friendships.
___ Parenting, child care, elder care.
___ Housework/work to maintain home.
___ Errands/routine activities.
___ Personal dress/hygiene.