

CLIENT NAME: _____ DATE: _____

PLEASE CHECK ANY SYMPTOMS YOU HAVE EXPERIENCED IN THE PAST MONTH:

- | | | |
|--|--|--|
| <input type="checkbox"/> Problems with my memory | <input type="checkbox"/> Being preoccupied with cleanliness | <input type="checkbox"/> Other problems with my parents |
| <input type="checkbox"/> Problems with knowing where I am | <input type="checkbox"/> Feeling emotionally “numb” | <input type="checkbox"/> Hard to make my child obey |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Recurring nightmares | <input type="checkbox"/> Losing my temper with my child |
| <input type="checkbox"/> Using alcohol excessively | <input type="checkbox"/> Trouble keeping my mind on a task | <input type="checkbox"/> Child has academic problems |
| <input type="checkbox"/> Using drugs | <input type="checkbox"/> Being troubled by painful memories | <input type="checkbox"/> Other problems with my child |
| <input type="checkbox"/> People following me or out to hurt me | <input type="checkbox"/> Feeling regret over things I’ve done | <input type="checkbox"/> Being sexually attracted to persons of my own sex |
| <input type="checkbox"/> Hearing voices | <input type="checkbox"/> Thinking about a frightening event | <input type="checkbox"/> Becoming aroused by children |
| <input type="checkbox"/> Seeing things or beings others don’t see | <input type="checkbox"/> Fear of having or getting a disease | <input type="checkbox"/> Lack of interest in sex |
| <input type="checkbox"/> Special messages coming to me | <input type="checkbox"/> Having trouble remembering things about my past | <input type="checkbox"/> Spending money on things I shouldn’t |
| <input type="checkbox"/> Thoughts being stolen from my mind | <input type="checkbox"/> Feeling strange & distant from myself | <input type="checkbox"/> Difficulty controlling my temper |
| <input type="checkbox"/> Trouble keeping track of my thoughts | <input type="checkbox"/> Feeling detached or “disconnected” from others | <input type="checkbox"/> Spells of violence |
| <input type="checkbox"/> Trouble keeping my mind on a task | <input type="checkbox"/> Feeling that I’ve lost time | <input type="checkbox"/> Temptation to hurt or punish |
| <input type="checkbox"/> Feeling up one minute & down the next | <input type="checkbox"/> Problems in my marriage or relationship | <input type="checkbox"/> Fear of crowds in public places |
| <input type="checkbox"/> My thoughts going faster than I can speak | <input type="checkbox"/> Being uninterested in my mate | <input type="checkbox"/> Fear of speaking in public |
| <input type="checkbox"/> Often feeling restless & irritable | <input type="checkbox"/> Sexual problems in my marriage or relationship | <input type="checkbox"/> Fear of heights |
| <input type="checkbox"/> Preoccupied w/ sexual thoughts & urges | <input type="checkbox"/> My mate being critical of me | <input type="checkbox"/> Feeling anxious and don’t know why |
| <input type="checkbox"/> Trouble making myself slow down | <input type="checkbox"/> Sexual infidelities in my relationship | <input type="checkbox"/> Feeling like something bad is going to happen |
| <input type="checkbox"/> Feeling that I’m no good | <input type="checkbox"/> Arguing with my mate | <input type="checkbox"/> Feeling that I have failed |
| <input type="checkbox"/> Losing interest in sex | <input type="checkbox"/> Other marital problems | <input type="checkbox"/> Feeling that I am worthless |
| <input type="checkbox"/> Gaining weight | <input type="checkbox"/> Taking laxatives to control weight | <input type="checkbox"/> Feeling that no one would want me |
| <input type="checkbox"/> Losing weight | <input type="checkbox"/> Vomiting to control my calorie intake | <input type="checkbox"/> Other fears |
| <input type="checkbox"/> Thinking about dying or killing myself | <input type="checkbox"/> Going on “eating binges” | <input type="checkbox"/> Worrying about how I look |
| <input type="checkbox"/> Feeling guilty about the past | <input type="checkbox"/> Conflicts with co-workers | <input type="checkbox"/> Feeling afraid of becoming fat |
| <input type="checkbox"/> Losing pleasure in daily activities | <input type="checkbox"/> Conflicts with my boss | <input type="checkbox"/> Feeling disgusted with myself |
| <input type="checkbox"/> Crying and tearful | <input type="checkbox"/> Conflicts with my family | <input type="checkbox"/> Don’t know where God is |
| <input type="checkbox"/> Sadness | <input type="checkbox"/> Losing someone close to me | <input type="checkbox"/> Feeling that God doesn’t care |
| <input type="checkbox"/> Feeling hopeless about the future | <input type="checkbox"/> Losing my hopes and dreams | <input type="checkbox"/> Feeling that I am being punished |
| <input type="checkbox"/> Having thoughts I can’t control | <input type="checkbox"/> An important romance ending | <input type="checkbox"/> Feeling God is angry with me |
| <input type="checkbox"/> Feeling the urge to check things | <input type="checkbox"/> Parents interfering with decisions | <input type="checkbox"/> Feeling God is disappointed in me |
| <input type="checkbox"/> Feeling the urge to avoid certain places or objects | <input type="checkbox"/> Arguing with my parents | <input type="checkbox"/> Can’t trust people |
| <input type="checkbox"/> Feeling troubled by repetitive thoughts | | |