MAPLEWOOD PSYCHOLOGY

Name _____ Date _____

SYMPTOM CHECKLIST

Please indicate all of the problems (symptoms) you experience. Rate these symptoms as they now affect your life. If problems don't apply, leave blank.

RATE YOUR DEGREE OF DISCOMFORT: **Mild = 1** **Moderate = 2** **Severe = 3**

_____ sad or empty mood
_____ loss of interest or pleasure
_____ decreased energy, fatigue
_____ sleep disturbance
  _____ insomnia
  _____ early morning wakening
  _____ oversleeping
_____ eating disturbance (loss or increase of appetite and weight)
_____ concentration
_____ memory
_____ making decisions
_____ less productive at work
_____ irritable
_____ excessive crying
_____ excessive worry, anxiety
_____ panic attacks
_____ stomach upset
_____ constipation or diarrhea
_____ aches and pains
_____ racing or obsessive thoughts

_____ headaches
_____ dizziness
_____ shortness of breath
_____ numbness/tingling
_____ unusual thoughts
_____ easily distracted
_____ thoughts of suicide
_____ unable to cope
_____ unable to have a good time
_____ can't make/keep friends
_____ feel apart from people
_____ fearful
_____ conflict with others
_____ feel worthless
_____ angry, ready to explode
_____ financial problems
_____ sexual problems
_____ unable to relax or slow down
_____ misuse alcohol, drugs, tobacco
_____ difficulty attending to personal hygiene
_____ worried about my health

CURRENT MEDICATIONS

Name of Medication	Dose/Frequency	Prescribing Doctor (name, phone)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____