ANDREWS & ASSOCIATES COUNSELING

CLIENT'S NAME:_____ **DATE:** _____

SYMPTOM CHECKLIST

Please check the symptoms you have experience in the **last year.**

SYMPTOM	Never or Rarely	Sometimes	Frequently	SYMPTOM	Never or Rarely	Sometimes	Frequently
Feel sad, unhappy				Financial problems			
Feel hopeless				Legal problems			
Feel worthless				Problems at work or school			
Feeling bad about self				Unable to make decisions			
Worry a lot				Thinking about suicide			
Feeling alone				Making plans for suicide			
Seem to be having less fun				Suicidal attempts			
Less social than usual				Hurting/Scratching/Burning self			
Irritable, angry				Thoughts about self- harm			
Uncontrollable temper				Wanting to hurt self			
Sudden mood changes				Pulling Hair			
Fidgety, unable to sit still				Panic attacks			
Daydream too much				Phobias			
Missing hours or days				Avoiding places/situations			
Easily distracted				Nightmares			
Racing thoughts				Flashbacks			
Having trouble concentrating				Compulsive behaviors			
Forgetfulness				Alcohol use (see page 2, yes)			
Tire easily, little energy				Drug use (see page 2, yes)			
Too much energy				Wanting to hurt others			
Sleep Problems				Violence towards others			
Trouble getting to sleep				Obsessive thoughts			
Increase in appetite				Repetitive Actions			
Decrease in appetite				Seeing things others don't			
Binging/overeating				Hearing things other don't			
Self-induced vomiting				Past or current physical abuse			
Unexpected weight gain				Past or current sexual abuse or assault			
Unexpected weight loss				Past or current emotional abuse			
Tingling or numbness				Excessive guilt			
Family problems				Health problems			
Headaches/Stomach aches				Other: _____			