

MAPLEWOOD PSYCHOLOGY P.A.

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 | _____ dizziness |
| _____ loss of interest or pleasure | _____ shortness of breath |
| _____ decreased energy, fatigue | _____ numbness/tingling |
| _____ sleep disturbance | _____ unusual thoughts |
| _____ insomnia | _____ easily distracted |
| _____ early a.m. wakening | _____ thoughts of suicide |
| _____ oversleeping | _____ unable to cope |
| _____ eating disturbance (loss or increase of appetite & weight) | _____ unable to have a good time |
| _____ concentration | _____ can't make/keep friends |
| _____ memory | _____ feel apart from people |
| _____ making decisions | _____ fearful |
| _____ less productive at work | _____ conflict with others |
| _____ irritable | _____ feel worthless |
| _____ excessive crying | _____ angry, ready to explode |
| _____ excessive worry, anxiety | _____ financial problems |
| _____ panic attacks | _____ sexual problems |
| _____ stomach upset | _____ unable to relax or slow down |
| _____ constipation or diarrhea | _____ misuse alcohol, drugs, tobacco |
| _____ aches and pains | _____ difficulty attending to personal |
| _____ racing or obsessive thoughts | _____ hygiene |
| _____ headaches | _____ worried about my health |

Current Medications

Name of medication	Dose/Frequency	Prescribing MD(Name & Phone #)
_____	_____	_____
_____	_____	_____