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| --- | --- | --- | --- | --- | --- |
| **Name:** |  | **DOB:** |  | **Date:** |  |

 **Client Symptom Checklist**

Please check off all that apply.

***In the past month…***

|  |
| --- |
| **1 (never) – 5 (often)** |
| 1. Do you feel sad, blue or empty, crying for no reason?
 |       |
| 1. Have you lost or gained a lot of weight recently?
 |      |
| 1. Do you have a hard time falling asleep, staying asleep or wake frequently?
 |      |
| 1. Do you feel fatigued or have loss of energy nearly every day?
 |      |
| 1. Do you feel a sense of guilt for things in the past?
 |      |
| 1. Do you feel that you don’t have anything to look forward to?
 |      |
| 1. Do you have difficulty concentrating or making decisions?
 |      |
| **1 (never) – 5 (often)** |
| 1. Do you have a lot of energy after getting very little sleep?
 |      |
| 1. Do you have angry outbursts that are difficult to control?
 |      |
| 1. Do you have a pounding heart or racing thoughts, feel shaky, tremble for apparent reason?
 |      |
| **1 (never) – 5 (often)** |
| 1. Do you have a difficult time leaving the house, taking public transportation, riding in elevators, etc.?
 |      |
| **1 (never) – 5 (often)** |
| 1. Do you have repetitive thoughts you can’t put out of your mind?
 |      |
| 1. Do you have rituals like checking if the stove is turned off, hand washing, counting, or repeating words silently?
 |      |
| **1 (never) – 5 (often)** |
| 1. Has anyone hurt or touched you in ways you didn’t want or have you witnessed someone being hurt?
 |      |
| 1. Do you have nightmares?
 |      |
| 1. Are you having difficulty at home?
 |      |
| 1. Are you having difficulty at work or school?
 |      |
| 1. If someone unexpectedly tapped you on the shoulder from behind, would you be startled or surprised?
 |      |
| 1. Did you lose a parent or caretaker before the age of 21?
 |      |
| 1. Do you feel disconnected from your feelings?
 |      |
| **1 (never) – 5 (often)** |
| 1. In the past month, have you ever thought you should cut down on your drinking or drug use?
 |      |
| 1. Do you use alcohol or drugs even though you know that it makes you depressed?
 |      |
| **1 (never) – 5 (often)** |
| 1. Do you eat a large amount of food in a short amount of time or “graze” all day?
 |      |
| 1. Do you restrict what you eat or yo-yo diet?
 |      |
| 1. Does how much you weigh dictate how you feel about yourself?
 |      |