Name ______________________________________ Date _____________________________________

SYMPTOM CHECKLIST

Please check all of the following problems/symptoms which apply to you.

_____ Panicky feelings
_____ Nervousness
_____ Anxiety
_____ Fears
_____ Procrastination
_____ Nervous tics
_____ Driven to perform certain behaviors
_____ Headaches
_____ Chest pains
_____ Rapid heartbeat
_____ Dizziness
_____ Excessive sweating
_____ Appetite problem
_____ Weight loss/gain
_____ Bowel/stomach trouble
_____ Bingeing
_____ Vomiting
_____ Purging
_____ Muscle tension
_____ Pain
_____ Hearing problems
_____ Menstrual problems
_____ Sexual problems
_____ Drug/alcohol abuse
_____ Depression
_____ Unhappiness
_____ Seasonal variations in mood
_____ Tearfulness
_____ Loss of interest
_____ Sleep problems
_____ Nightmares
_____ No sense of purpose
_____ Shyness
_____ Loneliness
_____ Relationship problems
_____ Educational problems
_____ Financial problems
_____ Career issues
_____ Boredom
_____ Temper outbursts
_____ Anger problems
_____ Loss of control
_____ Suspicious of others
_____ Hearing unidentified voices or sounds
_____ Guilt
_____ Jealousy
_____ Difficulty making decisions
_____ Homicidal thoughts
_____ Suicidal thoughts
_____ History of abuse
_____ Flash backs
_____ Time loss
_____ Feeling out of body
_____ Feeling unreal
_____ Smelling unidentified odors
_____ Sensitivity to noise or lights
_____ Racing thoughts
_____ Social isolation
_____ Reduced concentration
_____ Memory problems
_____ Low self-esteem
_____ Fatigue