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

_____ loss of interest or pleasure

_____ decreased energy, fatigue

_____ sleep disturbance

_____ insomnia

_____ early a.m. wakening

_____ oversleeping

_____ eating disturbance (loss or increase of appetite & 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 MD(Name & Phone #)
_____	_____	_____
_____	_____	_____