Ames Therapy & Consulting, P.C.

Symptom Checklist

Please complete the following symptom checklist. Mark all those that apply currently or in the recent past with an "x" and mark any you have experienced in the more distant past with a check mark.

Mark		Mark	
	Difficulty falling asleep		Unusual fears (please list below)
	Waking frequently throughout the night		Panic attacks
	Waking up early and cannot get back to sleep		Obsessive thoughts
	No appetite or over-eating		Nervousness
	Unplanned weight changes (amount ________)		Avoidance behaviors (please list below)
	Irritability		Re-living past trauma
	Frequent crying or crying for no reason		
	Loss of concentration		Hearing voices that others cannot
	Loss of motivation		Seeing things that others cannot
	No energy or low energy		
	Feeling tired all the time		Anger control problems
	Sad feelings or feeling empty		Violence toward others
	No interest in normally pleasurable activities		Destruction of property
	Staying away from friends		Gambling addiction
	Feeling worthless or guilty		Stealing
	Feeling hopeless		Fire-lighting
	Suicidal thoughts or attempts		Inappropriate sexual acting out
			Self-mutilation (cutting, burning, etc)
	Excite for no specific reason		Pulling out hair to relieve tension
	Excessive energy for activities		
	Going for days with little need of sleep (not tired)		Extreme attempts to control weight
	Racing thoughts (not nervousness)		Binge eating ("pigging out")
	Excessive talking		
	Unusually happy		Sexual problems
	Irritable or easily annoyed		
	Easily distracted		Fear of abandonment
	Feeling indestructible		Need to please others
	Spending sprees		
	Highly increased sex drive		

List fears: ____

List of avoidance behaviors: ____

Other symptoms you feel are important to mention:

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Please sign: ______________________________ Date: ___________