Please Mark Those That Apply to the Client

Client's Name_____ Date of Birth _____

☐ Depressed mood	☐ Shortness of breath dizziness, sweating
☐ Lost interest in activities previously enjoyed	☐ Recurrent undesirable thoughts
☐ Increased appetite	☐ Repetitive behaviors (handwashing) or mental acts (counting)
☐ Decreased appetite	☐ Nausea or abdominal stress
☐ Weight gain	☐ Fear of losing control
☐ Weight loss	☐ Fear of dying
☐ Difficulty going to sleep	☐ Recurrent intrusive memories
☐ Difficulty staying asleep	☐ Flashbacks
☐ Fatigue, loss of energy	☐ Efforts to avoid memories
☐ Feelings of worthlessness	☐ Fear of social situations
☐ Inappropriate guilt	☐ Alcohol problems
☐ Difficulty concentrating	☐ Drug use problems
☐ Preoccupation with death	☐ Compulsive dieting
☐ Suicidal thoughts	☐ Vomiting, use of laxatives
☐ Excessive or uncontrollable worry	☐ Marital problems
☐ Restlessness	☐ Sexual problems
☐ Irritable	☐ Impulsive
☐ Decreased need for sleep	☐ Overwhelmed
☐ Increased talking	☐ Angry
☐ Racing thoughts	☐ Easily upset, on edge
☐ Distractible	☐ Carless forgetful, easily distracted, difficulty organizing, loses things
☐ Elevated mood	☐
☐ Engaging in risky, pleasurable activities	☐
☐ Mood swings	☐
☐ Feeling of panic	☐
☐ Pounding heart, chest pains, shaking	☐

_____
Client's Signature

_____ _____
Parent/Caregiver's Printed Name Parent/Caregiver's Signature

_____
Date