

SYMPTOM CHECKLIST

The checklist below gives us a quick look at what difficulties you are currently experiencing or may have experienced in the past, and can provide a useful measure of your progress throughout therapy.

Please print this page and check any of the following that apply to you now or in the past.

<input type="checkbox"/> Past	<input type="checkbox"/> Now		<input type="checkbox"/> Past	<input type="checkbox"/> Now	
<input type="checkbox"/>	<input type="checkbox"/>	Feel sad, depressed, "blue" more often than not	<input type="checkbox"/>	<input type="checkbox"/>	Experience intense fears that limit me significantly
<input type="checkbox"/>	<input type="checkbox"/>	Feel tired, fatigued, low energy, or slowed down	<input type="checkbox"/>	<input type="checkbox"/>	Have trouble getting my breath sometimes
<input type="checkbox"/>	<input type="checkbox"/>	Cry easily	<input type="checkbox"/>	<input type="checkbox"/>	Suddenly feel scared for no apparent reason
<input type="checkbox"/>	<input type="checkbox"/>	Feel hopeless about the future	<input type="checkbox"/>	<input type="checkbox"/>	Sudden chills or hot flashes
<input type="checkbox"/>	<input type="checkbox"/>	Feel unable to make a difference in my situation	<input type="checkbox"/>	<input type="checkbox"/>	Heart pounding/racing
<input type="checkbox"/>	<input type="checkbox"/>	Poor concentration or motivation	<input type="checkbox"/>	<input type="checkbox"/>	Chest pains
<input type="checkbox"/>	<input type="checkbox"/>	Unable to forgive myself or blame myself	<input type="checkbox"/>	<input type="checkbox"/>	Trembling/shaking
<input type="checkbox"/>	<input type="checkbox"/>	Feel lonely or socially isolated from others	<input type="checkbox"/>	<input type="checkbox"/>	Feel nervous when left alone
<input type="checkbox"/>	<input type="checkbox"/>	Low self esteem or feel inferior to others at times	<input type="checkbox"/>	<input type="checkbox"/>	Feel stressed much of the time
<input type="checkbox"/>	<input type="checkbox"/>	Unable to ask for what I need or want	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety/panic
<input type="checkbox"/>	<input type="checkbox"/>	Unable to say no	<input type="checkbox"/>	<input type="checkbox"/>	Sweating
<input type="checkbox"/>	<input type="checkbox"/>	Find it difficult to express anger	<input type="checkbox"/>	<input type="checkbox"/>	Feel faint or dizzy
<input type="checkbox"/>	<input type="checkbox"/>	Feel angry, bitter, or resentful	<input type="checkbox"/>	<input type="checkbox"/>	Tingling or numbness
<input type="checkbox"/>	<input type="checkbox"/>	Feel the need to please others excessively	<input type="checkbox"/>	<input type="checkbox"/>	Fear of dying
<input type="checkbox"/>	<input type="checkbox"/>	Need to tell "white" or even blatant lies	<input type="checkbox"/>	<input type="checkbox"/>	Fear of going crazy
<input type="checkbox"/>	<input type="checkbox"/>	Unable to believe in my own worth	<input type="checkbox"/>	<input type="checkbox"/>	Feeling trapped or caught
<input type="checkbox"/>	<input type="checkbox"/>	Feel out of touch with my genuine needs & feelings	<input type="checkbox"/>	<input type="checkbox"/>	Feel a lump in my throat
<input type="checkbox"/>	<input type="checkbox"/>	Emotions seems to control my behavior	<input type="checkbox"/>	<input type="checkbox"/>	Headaches/migraines
<input type="checkbox"/>	<input type="checkbox"/>	Unable to have fun or not allowing myself to have fun	<input type="checkbox"/>	<input type="checkbox"/>	Nausea or often sick to my stomach
<input type="checkbox"/>	<input type="checkbox"/>	Not interested in things I usually enjoy	<input type="checkbox"/>	<input type="checkbox"/>	Tend to avoid certain things, places, or activities
<input type="checkbox"/>	<input type="checkbox"/>	Feel like I have little power or influence over my life	<input type="checkbox"/>	<input type="checkbox"/>	Feel afraid of open or large spaces
<input type="checkbox"/>	<input type="checkbox"/>	Feel like a victim much of the time	<input type="checkbox"/>	<input type="checkbox"/>	Have recurring dreams or nightmares
<input type="checkbox"/>	<input type="checkbox"/>	Keep making negative or self-defeating choices that end up hurting me or others	<input type="checkbox"/>	<input type="checkbox"/>	Unwanted or intrusive thoughts about abuse, trauma or other difficult events or experiences
<input type="checkbox"/>	<input type="checkbox"/>	Rarely express or receive physical affection	<input type="checkbox"/>	<input type="checkbox"/>	Easily startled
<input type="checkbox"/>	<input type="checkbox"/>	Loss of sexual interest or pleasure	<input type="checkbox"/>	<input type="checkbox"/>	Difficult to remember events in childhood
<input type="checkbox"/>	<input type="checkbox"/>	Lack meaningful/fulfilling connection to another person, family, group or pet	<input type="checkbox"/>	<input type="checkbox"/>	Sometimes feel detached or outside of my body watching myself do things
<input type="checkbox"/>	<input type="checkbox"/>	Feel criticized <i>by</i> others	<input type="checkbox"/>	<input type="checkbox"/>	Sometimes feel that I am not real
<input type="checkbox"/>	<input type="checkbox"/>	Feel critical <i>of</i> others	<input type="checkbox"/>	<input type="checkbox"/>	Sometimes feel that things around me are not real
<input type="checkbox"/>	<input type="checkbox"/>	Use alcohol, drugs, sex, work, food, etc. to cope	<input type="checkbox"/>	<input type="checkbox"/>	Lose track of time or have blank spells
<input type="checkbox"/>	<input type="checkbox"/>	Changes in appetite (circle: more or less)	<input type="checkbox"/>	<input type="checkbox"/>	Have flashbacks or vivid memories of certain events
<input type="checkbox"/>	<input type="checkbox"/>	Changes in sleep (circle: more or less)	<input type="checkbox"/>	<input type="checkbox"/>	Obsessive thoughts or compulsive behaviors
<input type="checkbox"/>	<input type="checkbox"/>	Thoughts of hurting myself or ending my life	<input type="checkbox"/>	<input type="checkbox"/>	In a physically or verbally abusive relationship
<input type="checkbox"/>	<input type="checkbox"/>	Previous suicide attempt(s): When? _____	<input type="checkbox"/>	<input type="checkbox"/>	Racing thoughts/difficulty holding onto an idea
<input type="checkbox"/>	<input type="checkbox"/>	Thoughts of hurting someone else	<input type="checkbox"/>	<input type="checkbox"/>	I hear or see things that other people don't
<input type="checkbox"/>	<input type="checkbox"/>	Feel angry or irritable	<input type="checkbox"/>	<input type="checkbox"/>	I hear voices inside my head
<input type="checkbox"/>	<input type="checkbox"/>	Easily agitated, annoyed or frustrated	<input type="checkbox"/>	<input type="checkbox"/>	Often feel I am not thinking clearly
<input type="checkbox"/>	<input type="checkbox"/>	Find it difficult to control my temper	<input type="checkbox"/>	<input type="checkbox"/>	Other problems or symptoms?
<input type="checkbox"/>	<input type="checkbox"/>	Find it difficult to control my spending or gambling	<input type="checkbox"/>	<input type="checkbox"/>	_____

Name: _____

Date: _____

Rev.1.1.09