Name: **DOB:** **Date:**

Client Symptom Checklist

Please check off all that apply.

In the past month…

	1 (never) – 5 (often)
1. Do you feel sad, blue or empty, crying for no reason?	❑ ❑ ❑ ❑ ❑
2. Have you lost or gained a lot of weight recently?	❑ ❑ ❑ ❑ ❑
3. Do you have a hard time falling asleep, staying asleep or wake frequently?	❑ ❑ ❑ ❑ ❑
4. Do you feel fatigued or have loss of energy nearly every day?	❑ ❑ ❑ ❑ ❑
5. Do you feel a sense of guilt for things in the past?	❑ ❑ ❑ ❑ ❑
6. Do you feel that you don't have anything to look forward to?	❑ ❑ ❑ ❑ ❑
7. Do you have difficulty concentrating or making decisions?	❑ ❑ ❑ ❑ ❑
	1 (never) – 5 (often)
8. Do you have a lot of energy after getting very little sleep?	❑ ❑ ❑ ❑ ❑
9. Do you have angry outbursts that are difficult to control?	❑ ❑ ❑ ❑ ❑
10. Do you have a pounding heart or racing thoughts, feel shaky, tremble for apparent reason?	❑ ❑ ❑ ❑ ❑
	1 (never) – 5 (often)
11. Do you have a difficult time leaving the house, taking public transportation, riding in elevators, etc.?	❑ ❑ ❑ ❑ ❑
	1 (never) – 5 (often)
12. Do you have repetitive thoughts you can't put out of your mind?	❑ ❑ ❑ ❑ ❑
13. Do you have rituals like checking if the stove is turned off, hand washing, counting, or repeating words silently?	❑ ❑ ❑ ❑ ❑
	1 (never) – 5 (often)
14. Has anyone hurt or touched you in ways you didn't want or have you witnessed someone being hurt?	❑ ❑ ❑ ❑ ❑
15. Do you have nightmares?	❑ ❑ ❑ ❑ ❑
16. Are you having difficulty at home?	❑ ❑ ❑ ❑ ❑
17. Are you having difficulty at work or school?	❑ ❑ ❑ ❑ ❑
18. If someone unexpectedly tapped you on the shoulder from behind, would you be startled or surprised?	❑ ❑ ❑ ❑ ❑
19. Did you lose a parent or caretaker before the age of 21?	❑ ❑ ❑ ❑ ❑
20. Do you feel disconnected from your feelings?	❑ ❑ ❑ ❑ ❑
	1 (never) – 5 (often)
21. In the past month, have you ever thought you should cut down on your drinking or drug use?	❑ ❑ ❑ ❑ ❑
22. Do you use alcohol or drugs even though you know that it makes you depressed?	❑ ❑ ❑ ❑ ❑
	1 (never) – 5 (often)
23. Do you eat a large amount of food in a short amount of time or "graze" all day?	❑ ❑ ❑ ❑ ❑
24. Do you restrict what you eat or yo-yo diet?	❑ ❑ ❑ ❑ ❑
25. Does how much you weigh dictate how you feel about yourself?	❑ ❑ ❑ ❑ ❑