NEW PATIENT
SYMPTOM CHECKLIST

Name:_____ Date:_____

INSTRUCTIONS: **Mark the appropriate box with an X to answer each question.** **Please be honest and be sure to answer all questions on the page.** **Indicate how much each of the following symptoms has been bothering you in the past week.**		**0- Not at all**	**1- Somewhat**	**2- Moderately**	**3- A lot**
CATEGORY I: DEPRESSION RELATED					
1	Sadness				
2	Weight loss/gain				
3	Quick mood				
4	Low motivation				
5	Hopeless/helpless changes				
6	Sleep issues				
7	Self-harm				
8	Lack of interest/pleasure in				
9	Distractibility				
10	Low energy				
11	Lack of focus/concentration				
12	Recurrent thoughts of death				
CATEGORY II: ANXIETY RELATED					
13	Heart palp				
14	Fear of leaving the house				
15	Chest pain				
16	Social phobia				
17	Sleep disturbance				
18	SOB				
19	Nervousness				
20	Constant Worry				
21	Specific fear (fill in blank) _____				
22	Obsessions/repetitive behaviors				
23	Irritability				
24	Muscle tension				
CATEGORY III: SUBSTANCE RELATED					
25	Under eating				
26	Alcohol abuse/addiction				
27	Binge Eating				
28	Gambling addition				
29	Purging				
30	Substance abuse/addition				
CATEGORY IV: GENDER OR SEXUALITY RELATED					
31	LGBT issues/concerns				
32	Gender dysphonia				
33	Other sexual issue (fill in blank) _____				
CATEGORY V: OTHER					
34	Paranoid				
35	Directly experiencing traumatic event				
36	hallucinations				
37	Recurrent distressing dreams/thoughts/memories				
38	auditory				
39	Visual				
40	Olfactory				