Name:____________________________________Date________________________

First, Please Print Form

Please review these symptoms. Rate each relevant complaint on a scale of 0-10, 10 being most severe. Ignore symptoms that are no a problem for you.

_____ Anorexia
_____ Bulimia
_____ Weight gain
_____ Weight loss
_____ Anxiety
_____ Anger (check which applies)
_______appropriate
_______inappropriate
_____ Bored
_____ Concentration
_____ Depressed Mood
_____ Decreased Energy
_____ Grief
_____ Guilt
_____ Hopelessness
_____ Irritability
_____ Mood Swings
_____ Worthless
_____ Suicidal
_____ Euphoria
_____ Mania
_____ Self injurious behavior
________cutting
________other?
_____ Hyperactivity
_____ Impulsivity
_____Spending
_____Substances
_____Sexual impulses
_____Other?
_____ _____Pain
_____ Where?______
_____ Health
_____ Pain
_____ Somatic Concerns
_____ Memory Problems
_____ Obsessions/Compulsions (check which applies?)
_____Doubting/Checking?
_____Contamination/cleansing?
_____Nonsensical impulses?internal repetition?
_____ Aggressive/Sexual/Horrific thoughts
_____Adhering to certain rules?
_____Counting?

_____ Panic Attacks
_____ Phobias Type?
_____
_____ Paranoia
_____ Sexual Fun no interest?
no enjoyment?
Obsessed?
_____ Sleep (chec _____Too much?
_____Insomnia?
_____Early morning awakening?
_____Nightmares?
_____ Substance _____Alcohol
_____Prescription Drugs
_____Other
_____ Relationshi _______Marriage/Partner
_____Children
_____Parents
_____Work
_____Other