Symptom Questionnaire

Sometimes stress can overwhelm us and we may experience many different symptoms. To better serve you, please complete the following questions as honestly and completely as possible. Thank you.

Name: _____ Date: _____

How would you describe your moods since your problem began? (check all that apply)

☐ Depressed ☐ Anxious or Nervous ☐ Guilty ☐ Angry ☐ Happy ☐ Irritable

How would you describe your attitude? Put an X on the box that best describes how you've been thinking

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

NO HOPE FOR THE FUTURE — **COMPLETE HOPE FOR FUTURE**

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

I CAN'T BE HELPED — **I CAN BE HELPED**

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

GENERALLY NOT CONFIDENT — **GENERALLY CONFIDENT**

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

I AM A WORTHLESS — **I AM JUST AS GOOD AS ANYONE**

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

WANT TO DIE — **WANT TO LIVE**

Behavioral / Emotional / Mental Symptoms: (Check all that apply)

☐Avoid certain situations ☐Worry excessively ☐Do Repetitive behaviors ☐Fears ☐Difficulty working

☐Compelled to do things ☐Withdrawing from others ☐Crying bouts ☐ Anger outbursts ☐Hearing things

☐People trying to harm you ☐ Seeing things ☐Relationship problems ☐Sudden mood swings ☐Procrastinating

☐ Concern with weight ☐"Losing" periods of time ☐Reluctance to leave home ☐Pain during sex ☐Binge eating

☐ Racing thoughts ☐Little or no interest in sex ☐Little sexual satisfaction ☐Sudden anxiety attacks

☐Forgetting things ☐Troubling sexual thoughts ☐Feel like losing control ☐Become disoriented ☐Lost interest in things

Sleeping:

About how many hours do you sleep per night? _____ Do you ever wake up during the night? _____

Do you sleep any during the day? _____ Do you take a regular nap during the day? _____

Do you sleep as much and as well as you would like? _____If "no", when was the last time you were satisfied with your sleeping? _____

If you have difficulty sleeping or sleep too much, do you know why? _____

If "yes", please state why _____

Memory / Concentration

Have you noticed any changes in your memory? _____

Are you having difficulty concentrating? _____

Are you having a harder time making decisions? _____

Eating

Describe how you eat. (number of meals per day, for example). _____

Have you been trying to gain or lose weight? _____

Are you satisfied with your appetite? _____If "No", why? _____

Have you lost or gained weight recently? _____ If so, how much? Lost_____ Gained_____

Since when? _____

Physical Symptoms **What have you been feeling consistently?** (check all that apply)

☐ Can go days without sleep ☐ Feeling of choking ☐Shaking/nervous ☐Fatigue ☐ Nausea/ vomiting

☐Peculiar smells noticed ☐Tics or Tremors ☐ Chest pain ☐Pain ☐Dry mouth

☐ Peculiar taste in mouth ☐ Peculiar taste in mouth ☐Lightheaded ☐Dizziness ☐ Restlessness

☐Sudden bursts of energy ☐Chills/ hot flashes ☐Sexual difficulty ☐Difficulty breathing ☐Heart palpitations

☐ Muscular weakness ☐ Accelerated heart rate ☐Other _____

Have you ever had:

☐A head injury ☐ Poor circulation ☐Cancer ☐Hyper/ Hypo Thyroidism ☐ Amnesia ☐Diabetes ☐High blood pressure ☐ Allergies ☐Blackouts ☐Heart Disease ☐ Stroke ☐Mitral Valve Prolapse

Onset and Experience of Symptoms

About when did your symptoms begin? _____

Did something happen then? _____

Are there certain times (days, time of day) during which you usually experience your symptoms? _____

_____

When is the last time you felt the way you wanted to feel? _____

Primary Care Physician: _____

Medication:_____ used for: _____

Medication:_____ used for: _____

Medication:_____ used for: _____

Medication:_____ used for: _____

Signature: _____ Date: _____