SYMPTOMS IDENTIFICATION LIST

PATIENT’S NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please state your presenting problem(s) and the length of time you have experienced it/them:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please take a few minutes to complete this survey. Circle the number that applies to you. The numbers range from 0-5 depending upon the severity of the symptom.

 0 1 2 3 4 5

 (No problem)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(severe problem)

Nervousness 0 1 2 3 4 5

Nightmares 0 1 2 3 4 5

Poor memory 0 1 2 3 4 5

Poor concentration 0 1 2 3 4 5

Worry all the time 0 1 2 3 4 5

Panic attacks 0 1 2 3 4 5

Feelings of dread 0 1 2 3 4 5

Loss of appetite 0 1 2 3 4 5

Sadness 0 1 2 3 4 5

Crying spells 0 1 2 3 4 5

Loss of interest in activities 0 1 2 3 4 5

Weight loss 0 1 2 3 4 5

Extreme tiredness 0 1 2 3 4 5

Headaches 0 1 2 3 4 5

Suicidal thoughts & plans 0 1 2 3 4 5

Suspiciousness 0 1 2 3 4 5

Hearing voices 0 1 2 3 4 5

Feelings of hopeless/ helplessness 0 1 2 3 4 5

Loss of interest in sex 0 1 2 3 4 5

Impulse control problems 0 1 2 3 4 5

Sleep Problems 0 1 2 3 4 5