

SYMPTOM SURVEY

Name _____

To assist in your evaluation, please answer the following questions by checking yes or no:

Have you or do you experience...

Yes No

- | | | |
|-------|-------|--|
| _____ | _____ | premenstrual syndrome? |
| _____ | _____ | witnessing a traumatic event? |
| _____ | _____ | recent weight loss? |
| _____ | _____ | recent weight gain? |
| _____ | _____ | recent loss of a loved one? |
| _____ | _____ | financial stresses? |
| _____ | _____ | problems with legal authorities? |
| _____ | _____ | any history of mental illness in your biological family? |
| _____ | _____ | alcohol or drug abuse in your biological family? |

Please answer the following questions by checking the appropriate response:

Do you...

Always Most of Some of Never
 the time the time

- | | | | | |
|-------|-------|-------|-------|---------------------------------------|
| _____ | _____ | _____ | _____ | have recurrent dreams? |
| _____ | _____ | _____ | _____ | have nightmares? |
| _____ | _____ | _____ | _____ | avoid specific events or places? |
| _____ | _____ | _____ | _____ | have an exaggerated startle response? |
| _____ | _____ | _____ | _____ | feel restless? |

Always Most of Some of Never
 the time the time

_____	_____	_____	_____	feel sad or empty?
_____	_____	_____	_____	feel worthless?
_____	_____	_____	_____	have a diminished sense of pleasure?
_____	_____	_____	_____	have a desire for excessive sleep?
_____	_____	_____	_____	have thoughts of death?
_____	_____	_____	_____	have suicidal thoughts?
_____	_____	_____	_____	have homicidal thoughts?
_____	_____	_____	_____	become easily distractible?
_____	_____	_____	_____	fear criticism?
_____	_____	_____	_____	feel inferior to others?
_____	_____	_____	_____	have difficulty making decisions?
_____	_____	_____	_____	have difficulty expressing disagreement?
_____	_____	_____	_____	fear being alone?
_____	_____	_____	_____	make decisions based on impulse?
_____	_____	_____	_____	have low self-esteem?
_____	_____	_____	_____	have little desire for sexual contact?
_____	_____	_____	_____	desire to stay at home?
_____	_____	_____	_____	feel tired?
_____	_____	_____	_____	have difficulty concentrating?
_____	_____	_____	_____	feel guilty?
_____	_____	_____	_____	have difficulty staying organized?
_____	_____	_____	_____	feel irritable?
_____	_____	_____	_____	feel out of control?
_____	_____	_____	_____	feel lonely?
_____	_____	_____	_____	become physically violent?

Always	Most of the time	Some of the time	Never	
_____	_____	_____	_____	have difficulty going to sleep?
_____	_____	_____	_____	have difficulty staying asleep?
_____	_____	_____	_____	feel nervous or shaky inside?
_____	_____	_____	_____	think that someone can control your thoughts?
_____	_____	_____	_____	feel that others are the cause of your problems?
_____	_____	_____	_____	have pains in your heart or chest?
_____	_____	_____	_____	experience fear in open spaces?
_____	_____	_____	_____	have significant changes in appetite?
_____	_____	_____	_____	feel suspicious toward others?
_____	_____	_____	_____	feel something is wrong with your mind?
_____	_____	_____	_____	have difficulty sitting still?
_____	_____	_____	_____	feel unappreciated by others?
_____	_____	_____	_____	feel nervous when alone?
_____	_____	_____	_____	have feelings of terror?
_____	_____	_____	_____	have little or no closeness with others?
_____	_____	_____	_____	feel uneasy in crowds?
_____	_____	_____	_____	have angry outbursts?
_____	_____	_____	_____	have difficulty completing tasks?
_____	_____	_____	_____	have little interest in ordinary life?
_____	_____	_____	_____	feel that people dislike you?
_____	_____	_____	_____	feel nauseated?
_____	_____	_____	_____	throw up?
_____	_____	_____	_____	feel easily hurt?

Always	Most of the time	Some of the time	Never	
_____	_____	_____	_____	have choking sensations?
_____	_____	_____	_____	feel that others are watching or talking about you?
_____	_____	_____	_____	check and double-check what you do?
_____	_____	_____	_____	fear traveling on public transportation?
_____	_____	_____	_____	feel self conscious around others?
_____	_____	_____	_____	have urges to break or smash something?
_____	_____	_____	_____	feel hopeless?
_____	_____	_____	_____	find your mind going blank?
_____	_____	_____	_____	have trouble catching your breath?
_____	_____	_____	_____	feel you deserve to be punished?
_____	_____	_____	_____	argue frequently with others?
_____	_____	_____	_____	feel depressed?
_____	_____	_____	_____	experience mood swings?
_____	_____	_____	_____	have obsessive thoughts?
_____	_____	_____	_____	feel tense or anxious?
_____	_____	_____	_____	have physical problems due to emotional stress?
_____	_____	_____	_____	have hallucinations?
_____	_____	_____	_____	have trouble with short-term memory?
_____	_____	_____	_____	have trouble with long-term memory?
_____	_____	_____	_____	become hostile?
_____	_____	_____	_____	have dissociative episodes?
_____	_____	_____	_____	have conflicts with authority figures?
_____	_____	_____	_____	cry?
_____	_____	_____	_____	isolate yourself rather than participate in social activities?

Alcohol use: ____ never, ____ less than 1 time a month, ____ 1-4 times a month,
____ 2-3 times per week, ____ daily.

Typically, how many ounces do you consume at one sitting? ____ ounces

Use of illegal substances: ____ never, ____ less than 1 time a month, 1-4 times a month,
____ 2-3 times per week, ____ daily. Substance(s): _____

Tobacco use: ____ never, ____ cigarettes per day.

Caffeine: ____ never, ____ caffeinated drinks per day.

Medication:

Are you allergic to any substances? YES ____ NO ____

If yes, please list the types of substances:

Are you currently on medication for reasons of mental health? YES ____ NO ____

If yes, what medication(s) and dosage(s) are you on?

If yes, please list the name, address and phone number of the prescribing physician:

Date of last physical exam: _____

Are you currently on prescription medication for reasons other than mental health?
YES ____ NO ____

If yes, what medication(s) and dosage(s) are you on?

If yes, please list the name, address and phone number of the prescribing physician:

Prior Treatment:

Have you previously undergone any mental health treatment? YES ____ NO ____

If yes, who was/were your provider/s?

If yes, during what periods of time?

What is your reason for seeking counseling today?
