Physician & Healthcare
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Name: _____ Date: _____

CHECKLIST OF CONCERNS

Please **CHECK** all symptoms or experiences that you have had repeatedly and interfering with your normal function **over the last six months**.

□ Difficulty falling asleep	□ Difficulty staying asleep
□ Early morning awakening	□ Restless sleep
□ Legs are restless and uncomfortable at night	□ Not feeling rested in the morning
□ Night terrors	□ Going to sleep or awakening and seeing things that are not there that terrify you
□ Sleep paralysis (awake but can't move)	□ Wake up gasping for breath
Average hours of sleep per night: _____	□ My mind races when I attempt to sleep
□ Persistent loss of interest in previously enjoyed activities	□ Withdrawing from other people
□ Spending increased time alone	□ Depressed mood
□ Feeling numb	□ Rapid mood changes
□ Anxiety	□ Panic attacks
□ Fear of social settings	□ Worry about not being close to your family
□ Frequent feelings of guilt	□ Avoiding people, places, activities, or specific things due to fear of contamination, germs,
□ Difficulty leaving your home for extended periods of time	□ Fear of certain objects or situations (flying, heights, bugs) What?_____
□ Repetitive behaviors or mental acts (counting, checking, doubting, washing)	□ Keeping items despite them not being useful
□ Outbursts of anger	□ Repeatedly pulling out hair or picking skin
□ Motor tics or vocal tics	□ Unable to feel in control of your thinking
□ Preoccupied with a perceived flaw in appearance	□ Feeling imperfect or something is wrong with you
□ Worthlessness	□ Hopelessness
□ Sadness	□ Helplessness
□ Fear	□ Feeling or acting like a different person
□ Feeling isolated	□ Feeling lonely
□ Thoughts of harming or killing yourself	□ Thoughts of harming or killing someone else
□ Changes in eating/appetite	□ Restricting intake of food
□ Eating more	□ Eating less
□ Binge eating excessive amounts of food	□ Use of laxative
□ Making yourself vomit	□ Excess exercise to avoid weight gain
□ Others comment on how skinny you are	□ Focused on losing weight. Frequent dieting

□ Weight gain: _____ lbs	□ Weight loss: _____ lbs
□ Difficulty catching your breath	□ Increased muscle tension
□ Unusual sweating	□ Easily startled, feeling "jumpy"
□ Increased energy. How long? _____	□ Decreased energy. How long? _____
□ Tremor	□ Dizziness
□ Frequent worry	□ Physical sensations others do not have
□ Racing thoughts	□ Intrusive memories
□ Difficulty concentrating or thinking	□ Large gaps in memory
□ Flashbacks	□ Nightmares
□ Feeling as if you are outside yourself & detached	□ Questioning what is real or unreal
□ Traumatic Brain Injury in the past year	□ A sense of being disoriented
□ Persistent, repetitive, intrusive thoughts & images	□ Unusual visual experiences such as flashes of light, shadows, colors
□ Hear voices when no one else is present	□ Feeling your thoughts are controlled or placed in your mind
□ Feeling that the tv or radio is communicating with you	□ You have special powers or abilities that others do not have
□ Smelling things that others are unable to smell	□ Feeling unusual sensations on or in your body
□ Difficulty problem solving	□ Difficulty getting things accomplished like usual
□ Worried you are being poisoned	□ Fear that others are out to get you or wrong you
□ Dependency on others	□ Manipulation of others to fulfill your own desires
□ Expressing anger / rage often	□ Self-mutilation / self-harm
□ Difficulty or inability to say "no" to others	□ Ineffective communication
□ Not reading social cues in groups or individually	□ Feeling like others are making fun of you or talking about you
□ Lack of control	□ Decreased ability to handle stress
□ Being abused by others (bullied, domestic violence)	□ Abusing others (bullying, domestic violence, etc.)
□ Difficulty expressing emotions	□ Difficulty communicating with others about your needs
□ Believing you are always right, smarter, and better than others	□ Lack confidence in yourself
□ Believe you do not have a purpose	□ Believe you do not have value
□ Relationship is falling apart	□ Fear of being alone
□ Frequent use of alcohol despite wanting to cut down	□ Use of illicit drugs or marijuana
□ Overuse of prescription medications to manage emotions	□ Aware your use of substances is more than you would like, or others have complained about it
□ Facing major changes in your life	□ Major health concerns
□ Other: _____	□ Other: _____