Kathy Kirstner, LPC 336-420-9340

Symptom Checklist

Date__________

Client Name ____

Please check all items that apply to you. You may add notes and details on the back.

All this information is strictly confidential

- ❒ have no problems or concerns
- ❒ Aggression, violence
- ❒ Anger, hostility, arguing, irritability
- ❒ Anxiety, nervousness
- ❒ Career concerns, goals, choices
- ❒ Childhood issues (your own childhood)
- ❒ Children, child management, child care, parenting
- ❒ Concentration, distractibility, disorganized thoughts, confusion, memory problems
- ❒ Decision making, indecision, mixed feelings, putting off decisions
- ❒ Delusions (false ideas)
- ❒ Dependence
- ❒ Depression, low mood, sadness, crying
- ❒ Divorce, separation
- ❒ Eating problems – overeating, under eating, appetite, vomiting, weight issues
- ❒ Fear of failure, or sensitivity to criticism
- ❒ Fatigue, tiredness, low energy
- ❒ Fears, phobias
- ❒ Financial or money troubles, debt, impulsive spending, low income
- ❒ Friendships
- ❒ Gambling
- ❒ Grieving, mourning, deaths, losses
- ❒ Guilt
- ❒ Hallucinations (hearing voices, seeing things)
- ❒ Health, illness, medical concerns, physical concerns, chronic pain
- ❒ History of abuse (physical, sexual, emotional)
- ❒ Homicidal thoughts or gestures (now- in past)
- ❒ Inferiority feelings, feeling worthless
- ❒ Impulsiveness, loss of control, outbursts
- ❒ Judgment problems, risk taking, irresponsibility
- ❒ Loneliness
- ❒ Mood swings
- ❒ Motivation
- ❒ Obsessions, compulsions (thoughts or actions that repeat themselves
- ❒ Panic or anxiety attacks
- ❒ Perfectionism
- ❒ Pessimism, or feelings of hopelessness
- ❒ Procrastination, work inhibitions
- ❒ Relationship problems
- ❒ School or academic problems
- ❒ Self centeredness
- ❒ Self esteem
- ❒ Self neglect, poor self care
- ❒ Sexual issues
- ❒ Sleep problems – too much, too little, insomnia, nightmares
- ❒ Smoking and tobacco use
- ❒ Stress, relaxation, stress management, stress disorders, tension
- ❒ Substance abuse – alcohol, prescription medication, over the counter medications, street drugs
- ❒ Suicidal thoughts or gestures (now or in the past)
- ❒ Temper problems, self control, low frustration tolerance
- ❒ Withdrawal, isolation
- ❒ Work problems

Any other concerns or issues____

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What is your proudest accomplishment?____

____

What are your strengths?____

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What are your family's strength's?____

____

Please look over the items you checked and choose the one that you most want help with at this time.

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Have you received any previous psychological services? If yes, please indicate when, where and from whom you received services.____

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Are you currently taking medication? If yes, please indicate what, how long, and for what reason.

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List any additional details for checked items ____

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Please provide any information that you feel may be helpful

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