illuminate
THERAPY & WELLNESS

SYMPTOMS CHECKLIST

Today's Date: _____

Client Name: _____

Person Completing Form (if different from Client): _____

Please indicate how often the following symptoms have occurred for the client in the last six months.

Area of Concern	Never/ Rarely	Sometimes	Often/More days than not	Daily	Area of Concern	Never/ Rarely	Sometimes	Often/More days than not	Daily
Feeling down and/or sad					Feeling anxious				
Feeling worthless					Feeling/experiencing panic				
Feeling hopeless					Fear of leaving home				
Loss of interest in activities/relationships					Struggles with social interactions				
Crying spells					Obsessive thoughts				
Feelings of guilt/shame					Compulsive behaviors				
Poor self-confidence					Easily startled				
Grief/Loss					Restlessness				
Thinking about death					Perfectionism				
Thinking about suicide					Trouble making decisions				
Sudden mood changes					Addictions: specify _____				
Absence from school/work					Tobacco use: cigarette/ e-cig/ vaping				
Difficulty concentrating					Alcohol use				
Easily distracted					Blackouts				
Impatience					Drug use: specify _____				
Irritability					Racing/intrusive thoughts				
Agitation					Hearing voices				
Feelings of jealousy					Hallucinations				
Financial problems					Homicidal thoughts				
Problems with family members					History of trauma				
Anger					Verbal/Emotional abuse (past/present)				
Aggression					Physical abuse (past/present)				
Stealing behaviors					Sexual abuse (past/present)				
Frequent lying					Self-injury				
Legal problems					Sexual dysfunction				
Low energy					Pornography				
Too much energy					Gastrointestinal issues				
Fatigue					Poor/no appetite				

Problems falling asleep					Weight loss/gain				
Problems staying asleep					Under eating/food restriction				
Sleeping too much/too little					Food and/or body preoccupation				
Nightmares					Overeating/Binging				
Chest pains					Vomiting				
Rapid heartbeat					Memory loss				
Shortness of breath					Feeling Tense				
Headaches					Chronic Illness				

Please let us know if there are other concerns you would like to discuss with your therapist:

_____

_____

_____