SOAR SERVICES, INC.

SYMPTOMS CHECKLIST

Name: _____ DOB: _____ DATE:_____

- ☐ Depression
- ☐ Low energy
- ☐ Low self-esteem
- ☐ Poor concentration
- ☐ Hopelessness
- ☐ Worthlessness
- ☐ Guilt
- ☐ Sleep disturbance
- ☐ Appetite disturbance
- ☐ Sadness
- ☐ Fears of dying
- ☐ Racing thoughts
- ☐ Irritability
- ☐ Easily angered/Annoyed
- ☐ Anxiety
- ☐ Nervousness
- ☐ Nightmares/Bad dreams
- ☐ Feeling thing around you are not real
- ☐ Difficult trusting
- ☐ Feeling you are not real
- ☐ Easily startled
- ☐ Panic feeling
- ☐ Heart pounding/Racing
- ☐ Tingling/Numbness
- ☐ Trembling/Shaking
- ☐ Sweating
- ☐ Phobias(fears)
- ☐ Fear of going crazy
- ☐ Difficulty breathing
- ☐ A lot of energy at times
- ☐ Need little sleep
- ☐ Obsessive/compulsive behaviors
- ☐ Excessive behaviors (spending, gambling,sex)
- ☐ Blackouts
- ☐ Excessive use of drugs/Alcohol
- ☐ Excessive use of prescription medications
- ☐ Blaming others
- ☐ Arguing
- ☐ Defies rules
- ☐ Unpleasant thoughts won't go away
- ☐ Anger/frustration
- ☐ Delusions(believe things others don't)
- ☐ Hallucinations(see,hear,smell things)
- ☐ Nausea
- ☐ Thoughts of hurting yourself
- ☐ Thoughts of hurting others
- ☐ Grieving
- ☐ Stomach problems
- ☐ Stress
- ☐ Chills/Hot flashes
- ☐ Headaches
- ☐ Spousal abuse issues
- ☐ Relationship issues
- ☐ Marital/Family/Child issues
- ☐ Physical abuse issues
- ☐ Lose track of time
- ☐ Can't hold on to a thought

What is your greatest concern?

What do you hope happens in counseling?