**Symptoms Check List**: Please indicate what symptoms you are experiencing and the severity by making it with a number between 1 and 10 with 10 being the most severe.

**Activity: Sleep Disturbance**

\_\_\_\_Decrease in energy or fatigue \_\_\_Early morning waking

\_\_\_Hyperactivity \_\_\_Hyper-somnia

\_\_\_Impulsive \_\_\_Insomnia

\_\_\_Restless

\_\_\_Physically slowed **Memory/ Attention**

\_\_\_Physically agitated \_\_\_Easily Distracted

\_\_\_Excessive social, work, or playful activities \_\_\_Difficulty Concentrating

\_\_\_Indecisive

**Behaviors:** \_\_\_Poor judgment

\_\_\_Work difficulties \_\_\_Memory loss

\_\_\_Aggressive

\_\_\_Violent **Thought and Speech**

\_\_\_Compulsions \_\_\_More talkative than usual

\_\_\_Dishonesty or theft \_\_\_Urge to keep talking

\_\_\_Destructive \_\_\_Racing thoughts

\_\_\_Disorganized \_\_\_Confused thinking

\_\_\_Oppositional or defiant \_\_\_Slurred speech

\_\_\_Reckless

\_\_\_Self-injurious **Perceptions and Thought Content**

\_\_\_Violation of the rules or rights of others \_\_\_Delusions

\_\_\_Legal problems \_\_\_Hallucinations (visual,sounds, touch,smells, etc.)

\_\_\_Bizarre or unusual thoughts

**Anxiety** \_\_\_Obsessive thoughts

\_\_\_Anxiousness \_\_\_Paranoid thoughts

\_\_\_Fear of separation \_\_\_Not feeling real/ depersonalization

\_\_\_Jitteriness \_\_\_Grandiose thoughts

\_\_\_Panic attacks \_\_\_Thoughts of suicide or death

\_\_\_Phobias \_\_\_Thoughts of a distressing event or flashbacks

\_\_\_Worry about \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Eating Disturbances**

**Mood \_\_\_**Binge eating

**\_\_\_**Mood swings \_\_\_Loss of appetite

\_\_\_Angry \_\_\_Increase in appetite

\_\_\_Tearfulness \_\_\_Inability to maintain a stable body weight

\_\_\_Depressed mood \_\_\_self-induced vomiting

\_\_\_Excessive guilty

\_\_\_Elevated mood **Substance Use**

\_\_\_Feeling worthless Type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_Helpless \_\_\_Work or family conflict over use

\_\_\_Hopeless \_\_\_Inability to decrease use

\_\_\_Irritability \_\_\_Persistent desire for substance

\_\_\_Hostility \_\_\_An increase in tolerance

\_\_\_Loss of interests \_\_\_Withdrawal symptoms

\_\_\_Loss of pleasure or apathy \_\_\_Excessive time to obtain, use, or recover

\_\_\_Low self-esteem \_\_\_Legal problems \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider name, credentials, and date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_