Sherman Counseling Psychiatric Assessment Symptom Checklist

Name_____ DOB_____ Today's date_____

What is your primary concern? Your reason for seeking treatment?

_____

_____

What medications have you tried, past or present, for mental health issues or sleep? (please consult your records if necessary)

_____

_____

Please indicate whether you struggle with any of the following problems (check the item):

Past	Present	
__	__	Low or sad mood for weeks or longer
__	__	Difficulty feeling joy or happiness
__	__	Pronounced irritability
__	__	Frequent low energy
__	__	Too much energy or feeling agitated
__	__	Sleeping too much
__	__	Not sleeping enough
__	__	Poor concentration
__	__	Eating too much
__	__	Poor appetite
__	__	Having difficulty doing day-to-day activities and caring for yourself
__	__	Thoughts of committing suicide
__	__	Self-injury
__	__	Aggression towards others
__	__	Excessive worry
__	__	Needing to do things in a ritualized or repetitive way
__	__	Checking and rechecking
__	__	Panic attacks
__	__	Avoiding social situations
__	__	Experiencing trauma, being a victim of violence
__	__	Nightmares or vivid recollections of the trauma
__	__	Feel very preoccupied with your body, weight, or appearance
__	__	Restricting your diet or purging
__	__	Doing impulsive things that cause problems
__	__	Acting aggressively (physically or verbally) towards others
__	__	Problematic gambling, spending, or other addictive behaviors
__	__	Problems with drugs, alcohol, or misusing prescription medications
__	__	Hearing or seeing things that others don't
__	__	Feeling paranoid or highly mistrustful of others
__	__	As a child: had problems with paying attention and/or feeling very fidgety/restless