MORGAN Counseling SERVICES LLC

Name:_______________________________________

Date:____________________________

SYMPTOM CHECKLIST

In order to get the most of our first session together, I would appreciate knowing more about the concerns that bring you in at this time. Below is a checklist that may help you describe what you're experiencing. Please check any items on the list that you have concerns about.

- ☐ Abuse (physical/emotional/sexual)
- ☐ Adultery
- ☐ Aggression, violence
- ☐ Alcohol/drug use
- ☐ Anger, hostility, arguing, irritability
- ☐ Anxiety, nervousness, panic
- ☐ ADD, ADHD
- ☐ Appetite change (more/less)
- ☐ Black outs/losing track of time
- ☐ Career or work related concerns
- ☐ Chest pain
- ☐ Childhood issues
- ☐ Concentration difficulty
- ☐ Codependence
- ☐ Confusion
- ☐ Compulsions
- ☐ Decision making
- ☐ Defiance of rules/norms
- ☐ Depression, low mood, tearful, sad
- ☐ Delusions (false ideas)
- ☐ Divorce
- ☐ Eating disorders/problems
- ☐ Excessive behaviors
- ☐ Fears:
  - ☐ That you are not real
  - ☐ That things are not real
  - ☐ Of dying
  - ☐ Of going crazy
  - ☐ Phobia ___________________
  - ☐ Other_____________________
- ☐ Financial problems
- ☐ Grief
- ☐ Guilt
- ☐ Hallucinations
- ☐ Health problems
- ☐ Heart racing
- ☐ Hopelessness
- ☐ Hot flashes/chills
- ☐ Impulsivity
- ☐ Irresponsibility
- ☐ Legal problems
- ☐ Low energy
- ☐ Low motivation
- ☐ Menstrual problems, menopause
- ☐ Mood swings
- ☐ Nausea
- ☐ Numbness/tingling
- ☐ Obsessions
- ☐ Pain
- ☐ Parenting
- ☐ Perfectionism
- ☐ Pornography
- ☐ Prescription Medication abuse
- ☐ Procrastination
- ☐ Racing thoughts
- ☐ Relationship problems
- ☐ Risk taking
- ☐ Self –esteem (too high/too low)
- ☐ Sweating excessively
- ☐ School problems
- ☐ Self-control
- ☐ Sexual issues
- ☐ Sleep disturbance (more/less)
- ☐ Social problems
- ☐ Stress
- ☐ Thoughts about death/dying
- ☐ Thoughts that won't go away
- ☐ Thoughts of hurting someone or you
- ☐ Trembling/Shaking
- ☐ Weight/dieting issues
- ☐ Withdrawal/Isolation
- ☐ Worthlessness