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Intake Symptom Checklist

Name:_____ Date:_____

Age: _____ Date of Birth:_____

Please briefly note the particular current concerns bringing you to our practice:

_____

_____

_____

_____

_____

_____

Please check any of the following experiences which apply to you. Feel free to add any pertinent information in the margins.

Mood Problems

☐ Sadness

☐ Negative self-concept

☐ Brooding / Stewing over negative thoughts

☐ Crying

☐ Loss (check all that apply)
☐ Loved one ☐ Job ☐ Home ☐ Other

☐ Grief

☐ Depression

☐ Increase/Decrease Appetite

☐ Loss of interest in previously pleasurable activity

☐ Low energy

☐ Change in sleep -- too much sleep / insomnia

☐ Decreased libido

☐ Anger

☐ Mania / too much energy / decreased need for sleep

Thought Processes

- [ ] Obsessive thinking
- [ ] Racing thoughts
- [ ] Difficulty concentrating
- [ ] Easily distracted
- [ ] Forgetfulness
- [ ] Getting lost in previously familiar locations

Self Regulation (Attention Deficit /Hyperactive Symptoms)

- [ ] Hyperactivity
- [ ] Impulsivity
- [ ] Difficulty keeping up with personal items
- [ ] Difficulty breaking large tasks down into smaller, more manageable components
- [ ] Being easily distracted / difficulty concentrating
- [ ] Forgetfulness
- [ ] Difficulty following through and completing tasks

Anxiety Symptoms

- [ ] Feeling anxious or nervous much of the time
- [ ] Fears / specific phobias (Specify:_____)
- [ ] Panic attacks
- [ ] Obsessive or repetitive thoughts that won't go away
- [ ] Repeating behaviors excessively (e.g., checking locks, washing hands repeatedly)
- [ ] Fear of encountering others in social situations
- [ ] Extreme anxiety in public speaking
- [ ] Excessive shyness

Interpersonal Concerns

- [ ] Social isolation / withdrawal from others
- [ ] Being overly dependent on others
- [ ] Being overly concerned with what others think about you
- [ ] Having your feelings hurt easily
- [ ] Excessive care-taking
- [ ] Problems taking care of self
- [ ] Difficulty with assertiveness / speaking your mind
- [ ] Difficulty with communication
- [ ] Family problems
- [ ] Parenting concerns
- [ ] Marital problems
- [ ] Other love relationship problems
- [ ] School or occupational difficulties
- [ ] Problems with sexual functioning

Physical Problems

- [ ] Headaches
- [ ] Physical illness
- [ ] Chronic pain
- [ ] Menstrual problems
- [ ] Physical problems in sexual functioning
- [ ] Head injury
- [ ] Other serious injury

Additional Symptoms

- [ ] Being unable to account for your daily activities during periods of time
- [ ] Seeming to "space out" / detachment or depersonalization
- [ ] Flashbacks from previous drug use
- [ ] Seeming to "numb out" or go blank at times
- [ ] Hearing things / auditory hallucinations
- [ ] Seeing things / visual hallucinations

Traumatic Experiences

- [ ] History of abuse from others
  - [ ] Emotional
  - [ ] Verbal
  - [ ] Physical
  - [ ] Sexual
- [ ] History of abuse toward others
  - [ ] Emotional
  - [ ] Verbal
  - [ ] Physical
  - [ ] Sexual
- [ ] Currently in danger of harming others
- [ ] Currently in danger of harm from others
- [ ] Currently in danger of harming self
  - [ ] Thoughts of suicide
  - [ ] Suicide plan
  - [ ] Cutting / self mutilation
- [ ] Experience of a traumatic event
  - [ ] Combat veteran
  - [ ] Violent Crime victim
  - [ ] Sexual Crime/rape victim
  - [ ] Accident / fire
  - [ ] Natural disaster
  - [ ] Tragic accident /victimization / death of a loved one
- [ ] Flashbacks to a traumatic event
- [ ] Nightmares / troubling dreams
- [ ] Avoidance behavior following a traumatic experience

Addictive or Compulsive Behaviors

	Self	Family Member
Alcohol overuse or abuse	☐	☐
Street drug use	☐	☐
Sexual addiction	☐	☐
Romance / relationship addiction	☐	☐
Compulsive gambling	☐	☐
Compulsive shopping	☐	☐
Compulsive overeating or diet restriction	☐	☐
Compulsive exercise	☐	☐
Compulsive overwork	☐	☐
Compulsive overuse of Internet	☐	☐

Other compulsive behavior (Specify:_____)

Please list current medication, dosage, and prescribing physician:

Medication Name	Dosage	Date Started	Prescribing Physician

Please put additional medications on the back of this sheet.

Primary Care Physician Name:_____ Phone:_____

Date of last physical examination: _____
Please describe any significant medical concerns:

Please describe previous psychiatric or psychotherapy treatment, inpatient or outpatient, with dates and outcomes:

Family history of psychological symptoms:_____

Maternal family:_____

Paternal family:_____

Educational History:

Current occupation and history:

Marital status/name and age of spouse or partner:

Do you have children? If so:
Name Age

Other pertinent information or history about yourself not previously covered that you feel may be helpful to your psychologist in helping you:

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