

## Symptom Checklist

Please mark those symptoms you are currently experiencing or you have experienced in the past 2-3 weeks.

- |  |   |
|--|---|
| <input type="checkbox"/> Agitated mood/irritable                             | <input type="checkbox"/> Worries about social situations                  |
| <input type="checkbox"/> Appetite change                                     | <input type="checkbox"/> Easily distracted                                |
| <input type="checkbox"/> Depressed mood                                      | <input type="checkbox"/> Avoid tasks that take time/effort                |
| <input type="checkbox"/> Excessive guilt                                     | <input type="checkbox"/> Poor attention to details                        |
| <input type="checkbox"/> Excessive time in bed                               | <input type="checkbox"/> Restless, fidget                                 |
| <input type="checkbox"/> Fatigue, energy decrease                            | <input type="checkbox"/> Short attention                                  |
| <input type="checkbox"/> Frequent crying                                     | <input type="checkbox"/> Talk excessively                                 |
| <input type="checkbox"/> Loss of interest in activities/hobbies              | <input type="checkbox"/> Have difficulty with organization                |
| <input type="checkbox"/> Low concentration                                   | <input type="checkbox"/> Have difficulty listening                        |
| <input type="checkbox"/> Low self-esteem                                     | <input type="checkbox"/> Changes in sexual desire, arousal or performance |
| <input type="checkbox"/> Sleep disturbance                                   |   |
| <input type="checkbox"/> Weight change                                       | Concern for self or partner regarding:                                    |
| <input type="checkbox"/> More talkative than usual, pressure to keep talking | <input type="checkbox"/> Gambling   |
| <input type="checkbox"/> Elevated mood                                       | <input type="checkbox"/> Alcohol Use                                      |
| <input type="checkbox"/> Decreased need for sleep                            | <input type="checkbox"/> Pornography                                      |
| <input type="checkbox"/> Racing thoughts                                     | <input type="checkbox"/> Prescription/non-prescription drug use           |
| <input type="checkbox"/> Excessive/unreasonable enthusiasm                   |   |
| <input type="checkbox"/> Nervousness   |   |
| <input type="checkbox"/> Shortness of breath                                 |   |
| <input type="checkbox"/> Chest pain  |   |
| <input type="checkbox"/> Heart palpitations                                  |   |
| <input type="checkbox"/> Sweating  |   |
| <input type="checkbox"/> Nausea  |   |
| <input type="checkbox"/> Dizziness   |   |
| <input type="checkbox"/> Frequent need for reassurance                       |   |
| <input type="checkbox"/> Panic attacks                                       |   |

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_