

Client Checklist Adult

Name: _____

Please indicate which of the following problems you have had recently, when you last experienced

| | Yes | No | When last experienced | How Often? | When problem began |
|---|-----|----|-----------------------|------------|--------------------|
| 1. Trouble remembering things | | | | | |
| 2. Spells of sudden fear that did not make sense | | | | | |
| 3. Trouble doing your job or school work | | | | | |
| 4. Weight loss or gain (amount: _____) | | | | | |
| 5. Unusual experiences that are hard to explain | | | | | |
| 6. Thought of dying | | | | | |
| 7. Someone thinks you drink too much or take too many drugs | | | | | |
| 8. Being in too many arguments | | | | | |
| 9. Avoiding things or places which most people do not avoid | | | | | |
| 10. Being in trouble | | | | | |
| 11. Feeling keyed up or on edge | | | | | |
| 12. Having peculiar thoughts | | | | | |
| 13. Difficulties with sexual matters | | | | | |
| 14. Increased stresses in your life | | | | | |
| 15. Sad mood | | | | | |
| 16. Irritability, easily annoyed | | | | | |
| 17. Poor concentration | | | | | |
| 18. Sleep problems | | | | | |
| 19. Low energy | | | | | |
| 20. Feeling disappointed in yourself | | | | | |
| 21. Headaches | | | | | |
| 22. Shortness of breath, chest pains | | | | | |
| 23. Dizziness, numbness | | | | | |
| 24. Trembling | | | | | |
| 25. Nausea, diarrhea, abdominal pains | | | | | |
| 26. Pains | | | | | |
| 27. Other (specify) | | | | | |

Signature _____

Date _____