PATIENT'S NAME: _____

DATE: _____

PLEASE LIST YOUR CURRENT MEDICATIONS:

_____

_____

_____

SYMPTOM CHECKLIST: Check all that apply

PHYSICAL		EMOTIONAL	
Headaches	____	Changes in personality	____
Backaches	____	Feelings of depression	____
Sexual Problems	____	Feelings of irritability	____
Significant weight change	____	Frequent racing thoughts	____
Numbness/weakness on either side of body	____	Anxiety/fear/panic	____
Heart pounding/racing	____	Feelings of unreality	____
Poor vision	____	Nervousness/shakiness	____
Sensitivity to light	____	Decreased energy	____
Sensitivity to noise	____	Fear of riding/driving in an automobile	____
Hearing impairment	____	Flashbacks	____
Tinnitus (ringing in the ears)	____	Thoughts of hurting yourself	____
Decrease/increase in appetite	____	Thoughts of hurting others	____
Change in taste	____		
Change in smell	____	**Emotional Total (0-12)** *for office use only:*	____
Loss of balance	____		
Poor coordination	____	**SLEEP**	
Nausea	____	Trouble falling asleep	____
Sweating hands/feet	____	Nightmares	____
Cold hands/feet	____	Sleeping more than usual	____
Teeth grinding/clenching	____	Sleeping less than usual	____
Pain	____		
Describe the location of the pain: _____			
_____			
Physical Total (0-21) *for office use only:*	____	**Sleep Total (0-4)** *office use only:*	____

COGNITIVE		SOCIAL	
Forgetfulness	____	Marital discord	____
Poor concentration	____	Problems with family/friends	____
Slowed thinking	____	Problems in work performance	____
Difficulty managing daily activities	____	Trouble participating in sports	____
Difficulty making decisions	____	Academic difficulties	____
Changes in judgement	____	Trouble participating in social settings	____
Difficulty understanding what others say	____		
Language/speech difficulty	____		
Explain language difficulty:			
_____			
_____			
Cognitive Total (0-8) *office use only:*	____	**Social Total (0-6)** *office use only:*	____