Name: **DOB:** **Date:**

Clinician Symptom Checklist

Please check off all that apply.

1 (never) -- 5 (often/daily)

Depression	**1 (never) – 5 (often)**
1. Do you feel sad or empty or do others think you are sad?	❑ ❑ ❑ ❑ ❑
2. Do you find yourself crying for no reason?	❑ ❑ ❑ ❑ ❑
3. Do you feel heavy inside?	❑ ❑ ❑ ❑ ❑
4. Have you lost or gained a lot of weight recently?	❑ ❑ ❑ ❑ ❑
5. Do you have a hard time falling asleep?	❑ ❑ ❑ ❑ ❑
6. Do you have a hard time staying asleep?	❑ ❑ ❑ ❑ ❑
7. Do you wake up rested?	❑ ❑ ❑ ❑ ❑
8. Do you or other people comment that you are always on the move, agitated or restless?	❑ ❑ ❑ ❑ ❑
9. Do you feel fatigued or have loss of energy nearly every day?	❑ ❑ ❑ ❑ ❑
10. Do you feel an inappropriate sense of guilt for things in the past?	❑ ❑ ❑ ❑ ❑
11. Do you feel that you don't have anything to look forward to?	❑ ❑ ❑ ❑ ❑
12. Do you have difficulty concentrating or making decisions?	❑ ❑ ❑ ❑ ❑
13. Do you find yourself with little or no pleasure in things that you think should give you pleasure?	❑ ❑ ❑ ❑ ❑
Mania	**1 (never) – 5 (often)**
1. Do you have persistent elevated, expansive or irritable mood?	❑ ❑ ❑ ❑ ❑
2. Do you have a lot of energy after getting very little sleep?	❑ ❑ ❑ ❑ ❑
3. Do you have a lot of energy that is hard to contain or control?	❑ ❑ ❑ ❑ ❑
4. Do you feel on top of the world, better than other people; that nothing can get to you?	❑ ❑ ❑ ❑ ❑
5. Do you feel rested after only 3 hours of sleep?	❑ ❑ ❑ ❑ ❑
6. Do you have racing thoughts or does it feel as though your thoughts sometimes run away from you?	❑ ❑ ❑ ❑ ❑
7. Do you take on a lot of projects at once?	❑ ❑ ❑ ❑ ❑
8. Do you go on buying sprees for things you don't need and/or don't have the money for but buy anyway?	❑ ❑ ❑ ❑ ❑
9. Do you do things that you or others think are risky but you feel driven to do them anyway?	❑ ❑ ❑ ❑ ❑
Anxiety & Panic	**1 (never) – 5 (often)**
1. Does your heart race or pound really hard?	❑ ❑ ❑ ❑ ❑
2. Do you find yourself sweating without having done something overly physical?	❑ ❑ ❑ ❑ ❑
3. Do you shake or tremble for no apparent reason?	❑ ❑ ❑ ❑ ❑
4. Do you feel short of breath or have the feeling you can't breathe?	❑ ❑ ❑ ❑ ❑
5. Do you feel like you have a lump in your throat or like you're chocking?	❑ ❑ ❑ ❑ ❑
6. Do you have chest pain, get nauseous or have butterflies in your stomach for no medical reason?	❑ ❑ ❑ ❑ ❑
7. Do you feel dizzy, unsteady, lightheaded or like you're going to faint?	❑ ❑ ❑ ❑ ❑
8. Do you feel like you're floating above yourself looking down at what's happening?	❑ ❑ ❑ ❑ ❑
9. Does it feel like you're looking at life through a gauze?	❑ ❑ ❑ ❑ ❑
10. Do your hands or feet ever feel numb with no medical reason?	❑ ❑ ❑ ❑ ❑
11. Do you get chills or hot flashes?	❑ ❑ ❑ ❑ ❑
12. Do you worry about having a panic attack?	❑ ❑ ❑ ❑ ❑
13. Does the fear of having a panic attack keep you from going out?	❑ ❑ ❑ ❑ ❑
Agoraphobia	**1 (never) – 5 (often)**
1. Do you have a difficult time going out of the house, taking public transportation, crossing bridges, riding in elevators, etc.?	❑ ❑ ❑ ❑ ❑
2. Does the thought of going out in public make you panic?	❑ ❑ ❑ ❑ ❑

3. When you're on public transportation, in an elevator or at a restaurant, do you need to be near the door?	❑ ❑ ❑ ❑ ❑
4. When in public, are you on the look-out for something bad to happen if you don't stay alert?	❑ ❑ ❑ ❑ ❑
5. Do you need or prefer that someone to go with you when you leave the house?	❑ ❑ ❑ ❑ ❑
Obsessions & Compulsions	**1 (never) – 5 (often)**
1. Do you have repetitive thoughts you can't put out of your mind?	❑ ❑ ❑ ❑ ❑
2. Do you engage in rituals or feel driven to do things like constant checking whether the stove is turned off, the door is closed, hand washing, praying, counting, or repeating words silently?	❑ ❑ ❑ ❑ ❑
3. Do you find that doing these activities prevent or relieve distressing thoughts or feelings?	❑ ❑ ❑ ❑ ❑
4. Do you need to allow yourself extra time to leave the house because of checking or the rituals?	❑ ❑ ❑ ❑ ❑
5. Even though you go through these rituals, you are still distressed, upset, or anxious?	❑ ❑ ❑ ❑ ❑
Trauma	**1 (never) – 5 (often)**
1. Has anyone hurt or touched you in ways you didn't want or have you witnessed someone being hurt?	❑ ❑ ❑ ❑ ❑
2. Do you have flashbacks, nightmares or recurring dreams from what happened during of past events?	❑ ❑ ❑ ❑ ❑
3. Do you try to avoid feeling, thinking or talking about events from the past that bother you?	❑ ❑ ❑ ❑ ❑
4. Are there people, places or things you avoid because they remind you of the past?	❑ ❑ ❑ ❑ ❑
5. Do you feel emotionally numb, as though you have no feelings or response to things that you "should" respond to?	❑ ❑ ❑ ❑ ❑
6. Do you have angry outbursts that can't be controlled?	❑ ❑ ❑ ❑ ❑
7. If someone tapped you on the shoulder from behind, would you be highly startled or surprised?	❑ ❑ ❑ ❑ ❑
8. Did you lose a parent or caretaker before the age of 21?	❑ ❑ ❑ ❑ ❑
Dissociation/Disorientation	**1 (seldom) – 5 (often)**
1. Do people call you by a different name?	❑ ❑ ❑ ❑ ❑
2. Do people insist they know you even though you don't recognize them?	❑ ❑ ❑ ❑ ❑
3. Do you find yourself in places and you don't remember how you got there?	❑ ❑ ❑ ❑ ❑
4. Do you feel as if you are looking at the world through a fog so that people and objects appear far away or unclear?	❑ ❑ ❑ ❑ ❑
5. Do you find things in your possession that you don't remember purchasing?	❑ ❑ ❑ ❑ ❑
6. Do people say you did something even though you don't remember doing it?	❑ ❑ ❑ ❑ ❑
7. Does time go by and you don't remember what happened?	❑ ❑ ❑ ❑ ❑
8. Do you feel like you're in a daze?	❑ ❑ ❑ ❑ ❑
9. Do you feel detached from every day experiences of yourself, like you are living in a movie and watching yourself?	❑ ❑ ❑ ❑ ❑
Alcohol & Drugs	**1 (never) – 5 (often)**
1. Has your alcohol/drug use stopped you from going to work, doing things around the house or going out socially?	❑ ❑ ❑ ❑ ❑
2. Do you use alcohol or drugs even though you know that it makes you depressed?	❑ ❑ ❑ ❑ ❑
3. Do you find yourself drinking/using drugs even though you have an ulcer/are on kidney dialysis?	❑ ❑ ❑ ❑ ❑
4. Have you ever gotten into work or legal problems because of your drinking / drug use?	❑ ❑ ❑ ❑ ❑
5. Do other people think that you drink too much or have a drug problem?	❑ ❑ ❑ ❑ ❑
6. Do you find yourself getting into fights with people or saying things you wish you hadn't said when you're drinking/using drugs?	❑ ❑ ❑ ❑ ❑
7. Do you find you need more to get the same high as you used to get?	❑ ❑ ❑ ❑ ❑
8. Do you find yourself wanting to stop or cut down but can't?	❑ ❑ ❑ ❑ ❑
Food & Body Image	**1 (never) – 5 (often)**
1. Do you eat a large amount of food in a short amount of time; more food than others usually eat?	❑ ❑ ❑ ❑ ❑
2. Do you eat when you don't feel hungry?	❑ ❑ ❑ ❑ ❑
3. Do you have trouble knowing if you are hungry or full without being famished or stuffed?	❑ ❑ ❑ ❑ ❑
4. Do you feel out of control when you eat or have a feeling that you cannot stop?	❑ ❑ ❑ ❑ ❑

5. Do you feel ashamed, disgusted or guilty after eating?	❑	❑	❑	❑	❑
6. Do you eat alone because of feeling embarrassed by how much you are eating?	❑	❑	❑	❑	❑
7. Do you feel in a daze when you eat?	❑	❑	❑	❑	❑
8. Do you restrict what you eat or feel like you yo-yo diet?	❑	❑	❑	❑	❑
9. Do you "graze" all day?	❑	❑	❑	❑	❑
10. Do you have an intense fear of gaining weight or becoming fat, even though you are underweight?	❑	❑	❑	❑	❑
11. Do you purge or deliberately thrown up after eating?	❑	❑	❑	❑	❑
12. Does how much you weigh dictate how you feel about yourself?	❑	❑	❑	❑	❑
13. Do you use exercise to justify what you eat?	❑	❑	❑	❑	❑
14. Do you use laxatives as a way to regulate your weight?	❑	❑	❑	❑	❑
15. Do you not buy clothes because you intend to lose weight first?	❑	❑	❑	❑	❑