Client Name _____Date_____

Symptom Checklist

	Check each of the following that you have experienced during the last 2 weeks:
	Sleep disturbance
	Appetite disturbance
	Fatigue
	Restlessness
	Change in medication
	Alcohol use
	Drug use
	Physical pain
	Racing thoughts
	Trouble concentrating
	Trouble remembering
	Feeling scattered
	Hard to stop talking
	Mood swings
	Feeling disorganized
	Suicidal ideation
	Homicidal ideation

	Dissociative episode
	Sad mood
	Anxious mood
	Panic attack
	Crying, tearfulness
	Nightmares
	Flashbacks to trauma
	Unresolved grief
	Loss of identity
	Loss of hope
	Feeling guilty
	Feeling disconnected
	Feeling used
	Feeling unworthy
	Isolating behavior
	Emotional shutdown
	Interpersonal stress
	Problems with trust

Reason for seeking therapy:

My signature below represents I have been informed of my rights and responsibilities as a client had that I have had the opportunity to ask questions and gather information.

Client signature:_____ Date:_____

Witness Signature:_____ Date:_____

Annabel Agee, PhD, LPC/MHSP, NCC TN LPC 2052 NPI 1407946056

AGEE FORM C-3 SYMPTOM CHECKLIST