REVIEW OF SYMPTOMS

NAME:_____DOB:_____DATE:_____

WHO IS YOUR PRIMARY CARE DR:_____THERAPIST:_____

IS IT OK IF WE SEND THEM PERIODIC UPDATES? YES OR NO (CIRCLE ONE)

PLEASE CHECK THE SYMPTOMS YOU HAVE EXPERIENCED IN THE PAST TWO WEEKS

YES	NO	CONSTITUTIONAL	YES	NO	MUSCULOSKELETAL
		DECREASED APPETITE			PAIN
		TIREDNESS			WEAKNESS
		PSYCHIATRIC			NEUROLOGIC
		TEARFULNESS			HEADACHES
		LACK OF PLEASURE			TREMOR/TICS
		SUICIDAL THOUGHTS			DIZZINESS
		PANIC ATTACKS			
		IRRITABILITY			GASTOINTESTINAL
		IMPULSIVENESS			INCREASED APPETITE
		RACING THOUGHTS			NAUSEA
		EXCESSIVE WORRY			CONSTIPATION
		POOR CONCENTRATION			DIARRHEA
		POOR TASK COMPLETION			
		POOR MOTIVATION			ENDOCRINE
		COMPULSIVE BEHAVIOR			HEAT OR COLD INTOLERANCE
					PMS
		HEENT			
		DRY MOUTH			GU
		BLURRY VISION			HIGH LIBIDO
					LOW LIBIDO
		CARDIOVASCULAR			DIFFICULTY URINATING
		INCREASED HEART RATE			INCONTINENCE
		CHEST PAIN			ERECTILE PROBLEMS
		PULMONARY			HEMATOLOGIC
		SHORTNESS OF BREATH			EASY BRUISING

ARE YOU USING ANY RECREATIONAL DRUGS? _____

HOW MANY ALCOHOLIC BEVERAGES ARE YOU CONSUMING WEEKLY? (1 BEER/6OZ WINE/1SHOT)_____

HOW MANY MINUTES DOES IT TAKE YOU TO FALL ASLEEP? _____

HOW MANY TIMES DO YOU WAKE UP AT NIGHT?_____

HOW MUCH WEIGHT HAVE YOU GAINED/LOST RECENTLY?_____

HOW WOULD YOU RATE YOUR MOOD 0-10 WITH TEN BEING YOUR BEST? _____

HOW WOULD YOU RATE YOUR NERVOUSNESS 0-10 WITH TEN BEING THE MOST ANXIOUS? _____