CENTER FOR HUMAN DEVELOPMENT

Client Checklist
Adult

Name: ____

	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. Thoughts 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 disappointment in yourself					
21. Headaches					
22. Shortness of breath, chest pains					
23. Dizziness, numbness					
24. Trembling					
25. Nausea, diarrhea, abdominal pains					
26. Pains					
27. History of head injury					
28. Has anyone inappropriately touched you?					
29. Has anyone hurt you?					
30. Other (specify)					

Medications or supplements currently taken	**Dosage**	**For**	**Prescribed by**

____ ______________________

Signature **Date**

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