

CENTER for HUMAN DEVELOPMENT

Client Checklist

Name: _____

Please indicate which of the following problems you have had recently, when you last experienced them, how often they have happened (*e.g. if once a week, write 1x/week*) and when the problem began.

	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)					

Please list any medications or supplements you are taking.

Medication	Dosage	For	Prescribed by
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Signature _____

Date _____