

## PERSONAL CHECKLIST

Please rate the following symptoms in terms of severity:

- 1 –Hardly Ever
- 2 –Occasionally
- 3 –Half the Time
- 4 –Almost all the Time
- 5 –All the Time

- |  |   |
|--|---|
| <input type="checkbox"/> feeling grouchy           | <input type="checkbox"/> frequent sweating      |
| <input type="checkbox"/> always tired              | <input type="checkbox"/> poor health            |
| <input type="checkbox"/> memory problems           | <input type="checkbox"/> constipation           |
| <input type="checkbox"/> lack energy               | <input type="checkbox"/> headaches              |
| <input type="checkbox"/> unable to have fun        | <input type="checkbox"/> fast heartbeat         |
| <input type="checkbox"/> poor appetite             | <input type="checkbox"/> dizziness              |
| <input type="checkbox"/> depressed                 | <input type="checkbox"/> hands shaky            |
| <input type="checkbox"/> trouble sleeping          | <input type="checkbox"/> stomach trouble        |
| <input type="checkbox"/> not enjoying things       | <input type="checkbox"/> have nightmares        |
| <input type="checkbox"/> loss of weight            | <input type="checkbox"/> nausea                 |
| <input type="checkbox"/> can't concentrate         | <input type="checkbox"/> sexual problems        |
| <input type="checkbox"/> crying spells             | <input type="checkbox"/> excessive drinking     |
| <input type="checkbox"/> dread holidays            | <input type="checkbox"/> drug use               |
| <input type="checkbox"/> loss of sexual interest   | <input type="checkbox"/> hands & feet cold      |
| <input type="checkbox"/> use of meds               | <input type="checkbox"/> diarrhea               |
| <input type="checkbox"/> suicidal thoughts         | <input type="checkbox"/> vomiting               |
| <input type="checkbox"/> can't make decisions      | <input type="checkbox"/> fainting spells        |
| <input type="checkbox"/> always worried            | <input type="checkbox"/> worry about death      |
| <input type="checkbox"/> unable to relax           | <input type="checkbox"/> shyness                |
| <input type="checkbox"/> anxious inside            | <input type="checkbox"/> can't handle money     |
| <input type="checkbox"/> muscles "jumping"         | <input type="checkbox"/> can't hold a job       |
| <input type="checkbox"/> feeling panic             | <input type="checkbox"/> financial problems     |
| <input type="checkbox"/> feeling tense             | <input type="checkbox"/> no one understands me  |
| <input type="checkbox"/> worry about health        | <input type="checkbox"/> feelings easily hurt   |
| <input type="checkbox"/> too much energy           | <input type="checkbox"/> problems at work       |
| <input type="checkbox"/> impatient with people     | <input type="checkbox"/> lonely                 |
| <input type="checkbox"/> overly sensitive          | <input type="checkbox"/> can't make friends     |
| <input type="checkbox"/> easily angered            | <input type="checkbox"/> don't like weekends    |
| <input type="checkbox"/> thoughts race             | <input type="checkbox"/> don't like being alone |
| <input type="checkbox"/> overly ambitious          | <input type="checkbox"/> don't like vacations   |
| <input type="checkbox"/> impatient with self       | <input type="checkbox"/> lack confidence        |
| <input type="checkbox"/> feel like smashing things | <input type="checkbox"/> problems with children |
| <input type="checkbox"/> easily excited            | <input type="checkbox"/> problem with parents   |
| <input type="checkbox"/> quick tempered            | <input type="checkbox"/> fighting/quarreling    |
| <input type="checkbox"/> feel like hurting someone | <input type="checkbox"/> marital problems       |

Name: \_\_\_\_\_

Date: \_\_\_\_\_

