STEPPING STONES COUNSELING CENTER, LLC

Client Checklist

Name:_____ Date:_____

Trouble remembering things?	Yes	No
Times of sudden fear that did not make sense?	Yes	No
Trouble doing your job or school work?	Yes	No
Weight loss or gain?	Yes	No
Unusual experiences which are hard to explain?	Yes	No
Thoughts of dying?	Yes	No
Someone thinks you drink too much or take too many drugs?	Yes	No
Being in too many arguments?	Yes	No
Avoiding things or places which most people do not avoid?	Yes	No
Being in trouble?	Yes	No
Feeling keyed up or on edge?	Yes	No
Having peculiar thoughts?	Yes	No
Difficulties with sexual matters?	Yes	No
Increased stressors in your life?	Yes	No
Sad mood?	Yes	No
Irritability, easily annoyed?	Yes	No
Poor concentration?	Yes	No
Sleep problems?	Yes	No
Low energy?	Yes	No
Feeling disappointed in yourself?	Yes	No
Headaches?	Yes	No
Shortness of breath, chest pains ?	Yes	No
Dizziness, numbness?	Yes	No
Trembling?	Yes	No
Nausea, diarrhea, abdominal pains?	Yes	No
Pains?	Yes	No

Other? Please specify:_____