Symptom Checklist

Name: _____ Date: _____

Please place a check for each symptom you have experienced over the last month.

1. _____ Feeling sad most of the day, more days than not
2. _____ Loss of interest in pleasurable activities
3. _____ Decreased energy and motivation
4. _____ Difficulty getting out of bed in the morning
5. _____ Isolating from others
6. _____ Thoughts/attempts of self-injurious behavior (e.g. cutting, burning, etc.)
7. _____ Thoughts/attempts of suicidal ideation
8. _____ Thoughts/attempts of homicidal ideation
9. _____ Significant and unintended weight loss or gain
10. _____ Racial/Ethnic based trauma
11. _____ Insomnia or hypersomnia nearly every day
12. _____ Feelings of worthlessness and/or inappropriate guilt
13. _____ Diminished ability to think or concentrate
14. _____ Difficulty focusing and keeping to a schedule
15. _____ Inability to relax
16. _____ Feeling keyed up or on edge
17. _____ Difficulties with peer group
18. _____ Academic difficulties
19. _____ Medical issues
20. _____ Financial concerns
21. _____ Concerns around LGBTQ+ issues
22. _____ Concerns around race/ethnicity issues
23. _____ Love and relationship issues
24. _____ Physical, emotional, and psychological abuse
25. _____ Sexual based trauma
26. _____ Family of origin issues
27. _____ Concerns over substance use
28. _____ Disordered eating
29. _____ Issues around communication
30. _____ Anger management
31. _____ Work and coop experiences
32. _____ Career concerns
33. _____ Body image and self-esteem
34. _____ Other (describe) _____