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Symptom Checklist[1]

Name of person completing form: ______________________ Today's date: ______________

Below is a list of symptoms and complaints that people sometimes have. Read each phrase carefully. Then, using the scale below, put a **CHECK MARK** in the **COLUMN** that best describes how often you have experienced the symptom over the **PAST SIX (6) MONTHS**. **DO NOT SKIP** any items. If you have any questions, please ask.

	never or hardly ever	sometimes	often	always or almost always
Headaches				
Faintness or dizziness				
Chronic pain				
Weakness, numbness or tingling in parts of your body				
Difficulty making decisions				
Worrying or stewing about things				
Keyed up, restless or agitated				
Easily fatigued				
Irritable				
Trouble remembering things				
Easily distracted				
Difficulty listening to others				
Losing things				
Behaving impulsively (without thinking)				
Loss of sexual interest or pleasure				
Poor appetite				
No interest in things				
Thinking about death or dying				
Hopeless about the future				
Sad or empty most of the day				
Racing thoughts				
Difficulty in falling asleep or staying asleep				
Unusual periods of happiness				
Involved in a task to the point of skipping meals, sleep or other important things				
Doing risky or harmful things (for example, spending money too freely, abusing drugs or alcohol, engaging in casual sex, driving carelessly)				
Feeling fine even when you get much less sleep than usual				
Unable to get rid of bad thoughts or ideas				
Bad dreams				
Fearful				
Heart pounding or racing				
Avoiding certain things, places, or activities because they frighten you				
Repetitive behaviors I have difficulty controlling				

[1] Adapted from the Hopkins Symptom Checklist-25 (HSCL-25)