

Cornerstone Counseling Center **Intake Symptom Checklist**

Please rate the following symptoms on a scale of 0 - 2

- 0= Not Significant, Non-Existent or Non-Issue
 1= Moderate or Sometimes
 2= Severe or Frequent Problem Area

	<u>Primary Client</u>	<u>Spouse or Parent</u>
Change in appetite or weight	_____	_____
Difficulties with falling, staying asleep or oversleeping	_____	_____
Excessive anger or easily frustrated	_____	_____
Mood Swings (depression - manic)	_____	_____
Excessive guilt or shame	_____	_____
Feelings or worthlessness or low self-esteem	_____	_____
Loss of energy	_____	_____
Decrease in concentration	_____	_____
Loss of interest in things, activities that were once enjoyed	_____	_____
Suicidal thoughts	_____	_____
Suicidal attempts	_____	_____
Lying	_____	_____
Manipulation	_____	_____
Poor impulse control	_____	_____
Hyperactive	_____	_____
Hallucinations, delusions, or thought distortions	_____	_____
Obsessive thoughts &/or compulsive behaviors	_____	_____
Change or loss of friends	_____	_____
Significant Losses (death of family member, loss of job, etc)	_____	_____
Excessive, addictive or abusive issues with: Alcohol	_____	_____
Drugs	_____	_____
Sex	_____	_____
Pornography	_____	_____
Gambling	_____	_____
Other?	_____	_____
Mental illness	_____	_____
Chronic physical illness	_____	_____
Sexual problems	_____	_____
Excessive financial problems	_____	_____
Unpredictable or out of control behavior	_____	_____
Self-mutilating behavior	_____	_____
Issues relating to religious beliefs	_____	_____
Excessive stress	_____	_____
Anxiety or excessive fears	_____	_____
Learning disabilities or under achievement	_____	_____
Work or School related problems	_____	_____

***Please briefly explain below your reason for coming to counseling -**