Cornerstone Counseling Center

Intake Symptom Checklist

Please rate the following symptoms on a scale of 0 - 2 (If the primary client is under the age of 16, then parents need to fill this out about their child):

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

	Primary Client	Spouse or Parent
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 -**