SYMPTOMS CHECKLIST: Please mark all items as they apply to you. Check only those items that affect you at least once or twice per week.

___Headaches
___Constipation
___Loose bowel movements
___Hot flashes
___Voice quivering or shaking
___Dry mouth
___Tightness in jaw
___Soreness of muscles
___Weakness in parts of your body
___Pains in heart or chest
___Smoking
___Itching/Hives
___Sweaty palms
___Feeling tense or nervous
___Shakiness
___Bad dreams
___Your mind going blank
___Difficulty making decisions
___Poor appetite
___Easily annoyed or irritated
___Easily crying
___Loss of sexual functioning
___Uncontrollable outbursts of temper
___Loss of sexual interest or desire
___Overeating
___Excessive urination
___Cold hands or feet
___Blushing
___Lump in throat
___Stuttering
___Grinding of teeth
___Lower back pains
___Heavy feeling - arms/legs
___Heart racing
___Allergies
___Tightness in stomach
___Nausea or upset stomach
___Trouble getting your breath
___Extreme fear of places or events
___Feeling fearful
___Feeling inferior to others
___Difficulty concentrating
___Thoughts of ending your life
___Worrying or stewing about things
___Loss of interest in things
___Difficulty in falling asleep
___Fatigue
___Desire to end your life

List all medications you are *currently* taking. Please include vitamins, herbs, supplements, and over-the-counter medicines.

Name of Medication	Dosage Amount/ Times per day	Usefulness

List all medications *previously* taken for the above indicated symptoms: _____

_____

List all health and medical conditions and surgeries (current and past) for which you have been diagnosed, treated for, or prescribed medications. Please include dates.

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____