

Checklist

Client Name _____ Female Male Non-binary

Date of Birth ____/____/____ Age _____

Email _____ Can we send e-mail to this address? Yes No

Phone _____ Can we leave a voicemail at this phone number? Yes No

Referring Provider Name _____ Date of Referral ____/____/____

Referring Provider Office Number _____ Fax Number _____

Symptom Checklist

- Incongruence with verbal and emotional expression
- Rapid weight changes and/or changes in eating behavior or appetite
- Rigid or perfectionistic thinking
- Changes in hygiene
- Changes in attention or concentration
- Evidence of suicide attempts or self-harm
- Depression or anxiety that doesn't seem to respond to medication
- Changes in sleep or sleep quality
- Increased injury
- Increased pressure to perform at work or at home
- Difficulty participating in activities or attending work
- Difficulty answering questions or asking for help
- Difficulty completing activities of daily living
- Difficulty engaging in social activities or reports of social isolation
- Lack of interest in activities
- Impulsive behavior
- Alterations in wardrobe or appearance (e.g., more baggy clothing, temperature inappropriate clothing)
- Anger outbursts
- "Surviving not thriving"
- Drug or alcohol issues

Additional Notes

