FAIRVIEW COUNSELING
OF CHESTER COUNTY

Symptom Assessment

Please give as accurate account as you can and if you have any questions or concerns, I invite you to discuss them with your therapist. Place a check in the box that best describes the frequency of your symptoms.
(N=Never, S=Sometimes, O=Often, A=Always)

I AM EXPERIENCING...	N	S	O	A	For how long?
Frequent worry or tension					
Fear of many things					
Discomfort in social situations					
Feelings of guilt					
Phobias: unusual fears about specific things					
Panic Attacks: Sweating, trembling, shortness of breath,					
heart palpitations					
Recurring, distressing thoughts about a trauma					
"Flashbacks" as if reliving the traumatic event					
Avoiding people/places associated with trauma					
Nightmares about traumatic experience					

I AM FEELING...	N	S	O	A	For how long?
Decreased interest in pleasurable activities					
Social Isolation, Loneliness					
Suicidal Thoughts					
Bereavement or Feelings of Loss					
Changes in sleep (too much or not enough)					
Normal, daily tasks require more effort					
Sad, hopeless about future					
Excessive feelings of guilt					
Low self-esteem					

I NOTICE...	N	S	O	A	For how long?
I am Angry, Irritable, hostile					
I feel euphoric, energized and highly					
optimistic					
I have racing thoughts					
I need less sleep than usual					
I am more talkative					
My moods fluctuate: go up and down					

I HAVE...	N	S	O	A	For how long?
Memory problems or trouble concentrating					
Trouble explaining myself to others					
Problems understanding what others tell me					
Intrusive or strange thoughts					
Obsessive Thoughts					

Been hearing voices when alone						
Problems with my speech						

I HAVE...	N	S	O	A	For how long?
Risk Taking behaviors					
Compulsive or repetitive behaviors					
Been acting without concern for consequence					
Been physically harming myself					
Been violent toward other(s)					
Thoughts about harming my children					

MY EATING INVOLVES…	N	S	O	A	For how long?
Restriction of food consumption					
Bingeing and Purging					
Binge Eating					
A lot of weight loss or gain					
I USE THE FOLLOWING....	N	S	O	A	For how long?
Alcohol					
Nicotine (Cigarettes)					
Marijuana					
Cocaine					
Opiates					
Sedatives					
Hallucinogens					
Stimulants					
Methamphetamines					
Prescription pain pills					
Synthetic drugs (ecstasy, weed, etc.)					

I HAVE...	N	S	O	A	For how long?
Concern about my sexual function					
Discomfort engaging in sexual activity					
Questions about my sexual orientation					
Questions about my gender expression					
Concern for my safety at home					
Concern for my safety outside					

EMPLOYMENT & SELF-CARE	N	S	O	A	For how long?
I have problems getting/keeping a job					
I have problems paying for basic expenses					
I am afraid of becoming homeless					
I have problems accessing healthcare					
I don't have reliable transportation					

Are there any other concerns that you'd like us to help with not indicated above?

_____

_____

_____