NEW HOPE CENTER -- Symptom Self-Assessment

Client's Name: ______________________________ Date: ______________________

CLIENT'S SYMPTOMS	PROBLEM		SEVERITY RATING			COMMENTS
Appetite	__No	__Yes	__Mild	__Mod	__Severe	____________
Energy Level	__No	__Yes	__Mild	__Mod	__Severe	____________
Concentration	__No	__Yes	__Mild	__Mod	__Severe	____________
Guilt/Hopeless	__No	__Yes	__Mild	__Mod	__Severe	____________
Libido	__No	__Yes	__Mild	__Mod	__Severe	____________
Sleep	__No	__Yes	__Mild	__Mod	__Severe	____________
Social functioning	__No	__Yes	__Mild	__Mod	__Severe	____________
Injurious/Suicidal	__No	__Yes	__Mild	__Mod	__Severe	____________
Weight (+ or -)	__No	__Yes	__Mild	__Mod	__Severe	____________
Anxiety/Panic	__No	__Yes	__Mild	__Mod	__Severe	____________
Memory	__No	__Yes	__Mild	__Mod	__Severe	____________
Thoughts	__No	__Yes	__Mild	__Mod	__Severe	____________
Drugs/Alcohol	__No	__Yes	__Mild	__Mod	__Severe	____________

Other statements: ____

____

Indicate Overall Mood: (circle one) Negative 1 2 3 4 5 6 7 8 9 10 Positive

In what areas are you having difficulty functioning? (Rate as: None, Mild, Moderate, Severe)

________ Job/School ________ Marriage/Relationship ________ Family _______ Social/Interpersonal

Suicidal: ___No ___Yes If Yes, Describe: ___Ideations ___Gestures ___Threats ___Plan

Describe actions taken: ____

Homicidal: ___No ___Yes

Describe actions taken: ____

Substance Abuse: ___No ___Yes

Describe actions taken: ____

List all Current Medications: ____

____

Compliance problems: ___No ___Yes

Describe: ____

Side effects: ___None ___Yes

Describe: ____

Note any recent changes in medications: ____

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____

Name of prescribing physician(s): ____

Phone: ____

If you wish to expand on any of these questions or provide other information, please continue on the reverse side.