

# Comprehensive Checklist

Name: \_\_\_\_\_

Date: \_\_\_\_\_

## Feelings

- |                                      |                                    |                                    |   |
|--------------------------------------|------------------------------------|------------------------------------|---|
| <input type="checkbox"/> Helpless    | <input type="checkbox"/> Anxious   | <input type="checkbox"/> Depressed | <input type="checkbox"/> Out of Control |
| <input type="checkbox"/> Ashamed     | <input type="checkbox"/> Afraid    | <input type="checkbox"/> Angry     | <input type="checkbox"/> Insecure       |
| <input type="checkbox"/> Guilty      | <input type="checkbox"/> Agitated  | <input type="checkbox"/> Hopeless  | <input type="checkbox"/> Restless       |
| <input type="checkbox"/> Worried     | <input type="checkbox"/> Lonely    | <input type="checkbox"/> Impatient | <input type="checkbox"/> Sad            |
| <input type="checkbox"/> Hopeful     | <input type="checkbox"/> Stressed  | <input type="checkbox"/> Inferior  | <input type="checkbox"/> Distrustful    |
| <input type="checkbox"/> Mood Shifts | <input type="checkbox"/> Irritable | <input type="checkbox"/> Panicked  | <input type="checkbox"/> Other_____     |

## Thoughts

- |                                      |  |  |  |
|--------------------------------------|--|--|--|
| <input type="checkbox"/> Confused    | <input type="checkbox"/> Racing Thoughts | <input type="checkbox"/> Forgetful         | <input type="checkbox"/> Worthless             |
| <input type="checkbox"/> Obsessive   | <input type="checkbox"/> Distracted      | <input type="checkbox"/> Unmotivated       | <input type="checkbox"/> Disorganized          |
| <input type="checkbox"/> Flashbacks  | <input type="checkbox"/> Paranoid        | <input type="checkbox"/> Negative Thoughts | <input type="checkbox"/> Suicidal              |
| <input type="checkbox"/> Sensitive   | <input type="checkbox"/> Poor body image | <input type="checkbox"/> Indecisive        | <input type="checkbox"/> Desire to hurt self   |
| <input type="checkbox"/> Preoccupied | <input type="checkbox"/> Legal Worries   | <input type="checkbox"/> Financial Stress  | <input type="checkbox"/> Desire to hurt others |
| <input type="checkbox"/> Suspicious  | <input type="checkbox"/> Other_____      | <input type="checkbox"/> Other_____        | <input type="checkbox"/> Other_____            |

## Behaviors

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Acting Out Sexually | <input type="checkbox"/> Losing Things      | <input type="checkbox"/> Procrastinates     | <input type="checkbox"/> Aggressive              |
| <input type="checkbox"/> Excessive Talking   | <input type="checkbox"/> Attempted Suicide  | <input type="checkbox"/> Disorganization    | <input type="checkbox"/> Parent/Child Conflicts  |
| <input type="checkbox"/> Poor Concentration  | <input type="checkbox"/> Impulsivity        | <input type="checkbox"/> Crying             | <input type="checkbox"/> Lack of Ambition/Goals  |
| <input type="checkbox"/> Recklessness        | <input type="checkbox"/> Poor Relationships | <input type="checkbox"/> Irritability       | <input type="checkbox"/> Withdrawing socially    |
| <input type="checkbox"/> Nightmares          | <input type="checkbox"/> Binging            | <input type="checkbox"/> Passivity          | <input type="checkbox"/> Violates Rules          |
| <input type="checkbox"/> Binge Drinking      | <input type="checkbox"/> Drug Use to Cope   | <input type="checkbox"/> Spiritual Problems | <input type="checkbox"/> Injuring Self           |
| <input type="checkbox"/> Alcohol Use to Cope | <input type="checkbox"/> Dating Concerns    | <input type="checkbox"/> Hyper Exercising   | <input type="checkbox"/> Avidant                 |
| <input type="checkbox"/> Compulsivity        | <input type="checkbox"/> Perfectionist      | <input type="checkbox"/> Driven             | <input type="checkbox"/> Decreased Sexual desire |
| <input type="checkbox"/> Restrictive Eating  | <input type="checkbox"/> Purging            | <input type="checkbox"/> Poor Eye Contact   | <input type="checkbox"/> Lying                   |
| <input type="checkbox"/> Isoation            | <input type="checkbox"/> Reactive           | <input type="checkbox"/> Stealing           | <input type="checkbox"/> Poor daily functioning  |
| <input type="checkbox"/> Depends on others   | <input type="checkbox"/> Hyperactive        | <input type="checkbox"/> Isolation          | <input type="checkbox"/> Other_____              |

## Physical Symptoms

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> Insomnia      | <input type="checkbox"/> Tired              | <input type="checkbox"/> Weight gain or loss | <input type="checkbox"/> Dizzy/lightheaded |
| <input type="checkbox"/> Headaches     | <input type="checkbox"/> Tightness in Chest | <input type="checkbox"/> Pain                | <input type="checkbox"/> Numbness/Tingling |
| <input type="checkbox"/> Vomiting      | <input type="checkbox"/> Rapid Heart Beat   | <input type="checkbox"/> Excessive Sleep     | <input type="checkbox"/> Loss of Memory    |
| <input type="checkbox"/> Stomach upset | <input type="checkbox"/> High Energy        | <input type="checkbox"/> Other_____          | <input type="checkbox"/> Other_____        |

## Experience at Workplace or Academic Setting

- |                                      |   |  |   |
|--------------------------------------|---|--|---|
| <input type="checkbox"/> Absenteeism | <input type="checkbox"/> Promoted           | <input type="checkbox"/> Demoted             | <input type="checkbox"/> Probation                |
| <input type="checkbox"/> Tardiness   | <input type="checkbox"/> Coworker conflicts | <input type="checkbox"/> Recently fired      | <input type="checkbox"/> Work problems            |
| <input type="checkbox"/> Other_____  | <input type="checkbox"/> Poor grades        | <input type="checkbox"/> Classmate conflicts | <input type="checkbox"/> Conflict with supervisor |