

AGAPE Symptom Checklist

Check all that apply regarding the *person who will be receiving counseling services*. Your counselor will review and discuss your responses with you during the intake interview. PLEASE USE BLACK INK ONLY.

Name of **counselee**: _____ Today's date: _____

Emotional symptoms

- | | | | |
|---------------------------------------|---|--------------------------------------|--|
| <input type="checkbox"/> anger | <input type="checkbox"/> depression | <input type="checkbox"/> anxiety | <input type="checkbox"/> extreme mood shifts |
| <input type="checkbox"/> irritability | <input type="checkbox"/> worry | <input type="checkbox"/> frustration | <input type="checkbox"/> helplessness |
| <input type="checkbox"/> hopelessness | <input type="checkbox"/> fear | <input type="checkbox"/> apathy | <input type="checkbox"/> lack of emotions |
| <input type="checkbox"/> guilt | <input type="checkbox"/> others (specify) _____ | | |

Notes (for counselor's use):

Mental symptoms

- | | | |
|--|--|--|
| <input type="checkbox"/> problems with concentration | <input type="checkbox"/> inattention | <input type="checkbox"/> memory problems |
| <input type="checkbox"/> difficulty making decisions | <input type="checkbox"/> distractibility | <input type="checkbox"/> racing thoughts |
| <input type="checkbox"/> repeated unwanted thoughts | <input type="checkbox"/> other (specify) _____ | |

Notes (for counselor's use):

Physical symptoms:

- | | | |
|---|--|---|
| <input type="checkbox"/> increase or decrease in appetite | <input type="checkbox"/> sleep difficulties | <input type="checkbox"/> muscle tension |
| <input type="checkbox"/> tearfulness/crying spells | <input type="checkbox"/> increased heart rate/pounding heart | <input type="checkbox"/> sweating/chills |
| <input type="checkbox"/> stomach or intestinal distress | <input type="checkbox"/> frequent or severe headaches | <input type="checkbox"/> body pain/numbness |
| <input type="checkbox"/> other (specify): _____ | | |

Notes (for counselor's use):

Behavioral symptoms:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> hyperactivity | <input type="checkbox"/> impulsivity | <input type="checkbox"/> binge eating/overeating | <input type="checkbox"/> suicidal gesture/attempt |
| <input type="checkbox"/> induced vomiting | <input type="checkbox"/> withdrawal | <input type="checkbox"/> arguing | <input type="checkbox"/> increased alcohol use |
| <input type="checkbox"/> fighting/aggression | <input type="checkbox"/> disorganized | <input type="checkbox"/> oppositional/defiant | <input type="checkbox"/> self-injury |
| <input type="checkbox"/> lying/deceitfulness | <input type="checkbox"/> avoidance of school or job | | |
| <input type="checkbox"/> other (specify) _____ | | | |

Notes (for counselor's use):