

# SYNERGY MENTAL HEALTH SERVICES – SYMPTOM CHECKLIST

Please review the following list of symptoms and check each that you are currently (Cx) experiencing or have a history (Hx) with. Do not omit any symptoms because you are not concerned with them.

**Client Name:** \_\_\_\_\_ **Client ID:** \_\_\_\_\_

<b>Category 1: Sleep</b>	<b>Cx</b>	<b>Hx</b>		<b>Cx</b>	<b>Hx</b>
Bruxism (Teeth Grinding)	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty falling asleep	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty maintaining sleep	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty waking	<input type="checkbox"/>	<input type="checkbox"/>
Dysregulated sleep cycle	<input type="checkbox"/>	<input type="checkbox"/>	Narcolepsy	<input type="checkbox"/>	<input type="checkbox"/>
Night sweats	<input type="checkbox"/>	<input type="checkbox"/>	Night terrors	<input type="checkbox"/>	<input type="checkbox"/>
Nightmares or vivid dreams	<input type="checkbox"/>	<input type="checkbox"/>	Nocturnal enuresis	<input type="checkbox"/>	<input type="checkbox"/>
Periodic leg movements	<input type="checkbox"/>	<input type="checkbox"/>	Restless leg	<input type="checkbox"/>	<input type="checkbox"/>
Restless sleep	<input type="checkbox"/>	<input type="checkbox"/>	Sleep apnea	<input type="checkbox"/>	<input type="checkbox"/>
Sleep walking	<input type="checkbox"/>	<input type="checkbox"/>	Snoring	<input type="checkbox"/>	<input type="checkbox"/>
Talking during sleep	<input type="checkbox"/>	<input type="checkbox"/>			

<b>Category 2: Attention &amp; Learning</b>	<b>Cx</b>	<b>Hx</b>		<b>Cx</b>	<b>Hx</b>
Difficulty completing tasks	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty following directions	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty making decisions	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty organizing personal time/space	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty remembering names	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty shifting attention	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty shifting tasks	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty thinking clearly	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty understanding conversations	<input type="checkbox"/>	<input type="checkbox"/>	Distractibility	<input type="checkbox"/>	<input type="checkbox"/>
Lack of alertness	<input type="checkbox"/>	<input type="checkbox"/>	Lacking common sense	<input type="checkbox"/>	<input type="checkbox"/>
Messy handwriting	<input type="checkbox"/>	<input type="checkbox"/>	Not listening	<input type="checkbox"/>	<input type="checkbox"/>
Poor concentration	<input type="checkbox"/>	<input type="checkbox"/>	Poor drawing ability	<input type="checkbox"/>	<input type="checkbox"/>
Poor math	<input type="checkbox"/>	<input type="checkbox"/>	Poor short-term memory	<input type="checkbox"/>	<input type="checkbox"/>
Poor sustained attention	<input type="checkbox"/>	<input type="checkbox"/>	Poor verbal expression	<input type="checkbox"/>	<input type="checkbox"/>
Poor vocabulary	<input type="checkbox"/>	<input type="checkbox"/>	Poor word finding	<input type="checkbox"/>	<input type="checkbox"/>
Reading difficulty	<input type="checkbox"/>	<input type="checkbox"/>	Slow thinking	<input type="checkbox"/>	<input type="checkbox"/>
Unmotivated	<input type="checkbox"/>	<input type="checkbox"/>			

<b>Category 3: Sensory</b>	<b>Cx</b>	<b>Hx</b>		<b>Cx</b>	<b>Hx</b>
Auditory hypersensitivity	<input type="checkbox"/>	<input type="checkbox"/>	Chemical sensitivities	<input type="checkbox"/>	<input type="checkbox"/>
Motion sickness	<input type="checkbox"/>	<input type="checkbox"/>	Poor body awareness	<input type="checkbox"/>	<input type="checkbox"/>
Somatosensory deficits	<input type="checkbox"/>	<input type="checkbox"/>	Tactile hypersensitivity	<input type="checkbox"/>	<input type="checkbox"/>
Tinnitus (Ears Ringing)	<input type="checkbox"/>	<input type="checkbox"/>	Vertigo (Dizziness)	<input type="checkbox"/>	<input type="checkbox"/>
Visual deficits	<input type="checkbox"/>	<input type="checkbox"/>	Visual hypersensitivity	<input type="checkbox"/>	<input type="checkbox"/>

<b>Category 4: Behaviors</b>	<b>Cx</b>	<b>Hx</b>		<b>Cx</b>	<b>Hx</b>
Addictive behaviors	<input type="checkbox"/>	<input type="checkbox"/>	Aggressive behavior	<input type="checkbox"/>	<input type="checkbox"/>
Anorexia	<input type="checkbox"/>	<input type="checkbox"/>	Autistic stimming	<input type="checkbox"/>	<input type="checkbox"/>
Binging and purging	<input type="checkbox"/>	<input type="checkbox"/>	Class clown	<input type="checkbox"/>	<input type="checkbox"/>
Compulsive behaviors	<input type="checkbox"/>	<input type="checkbox"/>	Compulsive eating	<input type="checkbox"/>	<input type="checkbox"/>
Crying	<input type="checkbox"/>	<input type="checkbox"/>	Excessive talking	<input type="checkbox"/>	<input type="checkbox"/>
Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	Impulsivity	<input type="checkbox"/>	<input type="checkbox"/>
Inflexibility	<input type="checkbox"/>	<input type="checkbox"/>	Lack of appetite awareness	<input type="checkbox"/>	<input type="checkbox"/>
Lack of sense of humor	<input type="checkbox"/>	<input type="checkbox"/>	Lack of social interest	<input type="checkbox"/>	<input type="checkbox"/>
Manipulative behavior	<input type="checkbox"/>	<input type="checkbox"/>	Motor or vocal tics	<input type="checkbox"/>	<input type="checkbox"/>
Nail biting	<input type="checkbox"/>	<input type="checkbox"/>	Oppositional or defiant behavior	<input type="checkbox"/>	<input type="checkbox"/>
Poor eye contact	<input type="checkbox"/>	<input type="checkbox"/>	Poor grooming	<input type="checkbox"/>	<input type="checkbox"/>
Poor social or emotional reciprocity	<input type="checkbox"/>	<input type="checkbox"/>	Poor speech articulation	<input type="checkbox"/>	<input type="checkbox"/>
Rages	<input type="checkbox"/>	<input type="checkbox"/>	Self-injurious behavior	<input type="checkbox"/>	<input type="checkbox"/>
Stuttering	<input type="checkbox"/>	<input type="checkbox"/>			

# SYNERGY MENTAL HEALTH SERVICES – SYMPTOM CHECKLIST

<b>Category 5: Emotional</b>		<b>Cx</b>	<b>Hx</b>		<b>Cx</b>	<b>Hx</b>
Agitation	<input type="checkbox"/>	<input type="checkbox"/>	Anger	<input type="checkbox"/>	<input type="checkbox"/>	
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	
Difficult to soothe	<input type="checkbox"/>	<input type="checkbox"/>	Dissociative episodes	<input type="checkbox"/>	<input type="checkbox"/>	
Easily embarrassed	<input type="checkbox"/>	<input type="checkbox"/>	Emotional reactivity	<input type="checkbox"/>	<input type="checkbox"/>	
Fears	<input type="checkbox"/>	<input type="checkbox"/>	Feelings of unreality	<input type="checkbox"/>	<input type="checkbox"/>	
Flashbacks of trauma	<input type="checkbox"/>	<input type="checkbox"/>	Impatience	<input type="checkbox"/>	<input type="checkbox"/>	
Irritability	<input type="checkbox"/>	<input type="checkbox"/>	Lack of emotional awareness	<input type="checkbox"/>	<input type="checkbox"/>	
Lack of pleasure	<input type="checkbox"/>	<input type="checkbox"/>	Lack of social awareness	<input type="checkbox"/>	<input type="checkbox"/>	
Low self-esteem	<input type="checkbox"/>	<input type="checkbox"/>	Mania	<input type="checkbox"/>	<input type="checkbox"/>	
Mood swings	<input type="checkbox"/>	<input type="checkbox"/>	Obsessive negative thoughts	<input type="checkbox"/>	<input type="checkbox"/>	
Obsessive worries	<input type="checkbox"/>	<input type="checkbox"/>	Panic attacks	<input type="checkbox"/>	<input type="checkbox"/>	
Paranoia	<input type="checkbox"/>	<input type="checkbox"/>	Suicidal thoughts	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Category 6: Physical</b>		<b>Cx</b>	<b>Hx</b>		<b>Cx</b>	<b>Hx</b>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	
Chronic constipation	<input type="checkbox"/>	<input type="checkbox"/>	Clumsiness	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty walking or moving	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty working	<input type="checkbox"/>	<input type="checkbox"/>	
Effort fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Encopresis	<input type="checkbox"/>	<input type="checkbox"/>	
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Heart palpitations	<input type="checkbox"/>	<input type="checkbox"/>	
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Hot flashes	<input type="checkbox"/>	<input type="checkbox"/>	
Immune deficiency	<input type="checkbox"/>	<input type="checkbox"/>	Irritable bowel	<input type="checkbox"/>	<input type="checkbox"/>	
Low muscle tone	<input type="checkbox"/>	<input type="checkbox"/>	Muscle tension	<input type="checkbox"/>	<input type="checkbox"/>	
Muscle twitches	<input type="checkbox"/>	<input type="checkbox"/>	Muscle weakness	<input type="checkbox"/>	<input type="checkbox"/>	
Nausea	<input type="checkbox"/>	<input type="checkbox"/>	PMS symptoms	<input type="checkbox"/>	<input type="checkbox"/>	
Poor balance	<input type="checkbox"/>	<input type="checkbox"/>	Poor fine motor coordination	<input type="checkbox"/>	<input type="checkbox"/>	
Poor gross motor coordination	<input type="checkbox"/>	<input type="checkbox"/>	Reflux / Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	
Rigidity	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	
Skin rashes	<input type="checkbox"/>	<input type="checkbox"/>	Spasticity	<input type="checkbox"/>	<input type="checkbox"/>	
Stress incontinence	<input type="checkbox"/>	<input type="checkbox"/>	Sugar craving and reactivity	<input type="checkbox"/>	<input type="checkbox"/>	
Sweating	<input type="checkbox"/>	<input type="checkbox"/>	Tachycardia	<input type="checkbox"/>	<input type="checkbox"/>	
Tremor	<input type="checkbox"/>	<input type="checkbox"/>	Urge incontinence	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Category 7: Pain</b>		<b>Cx</b>	<b>Hx</b>		<b>Cx</b>	<b>Hx</b>
Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	Chronic aching pain	<input type="checkbox"/>	<input type="checkbox"/>	
Chronic nerve pain	<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia pain	<input type="checkbox"/>	<input type="checkbox"/>	
Jaw pain	<input type="checkbox"/>	<input type="checkbox"/>	Joint pain	<input type="checkbox"/>	<input type="checkbox"/>	
Migraine headaches	<input type="checkbox"/>	<input type="checkbox"/>	Muscle pain	<input type="checkbox"/>	<input type="checkbox"/>	
Muscle tension headaches	<input type="checkbox"/>	<input type="checkbox"/>	Sciatica	<input type="checkbox"/>	<input type="checkbox"/>	
Sinus headaches	<input type="checkbox"/>	<input type="checkbox"/>	Stomach aches	<input type="checkbox"/>	<input type="checkbox"/>	
Trigeminal neuralgia	<input type="checkbox"/>	<input type="checkbox"/>				

SERVICES