Symptom Checklist: **Date __________** **Name ____________________________________**

Rate each symptom on a scale of 1 to 10 (l0, is most severe). Describe when possible (write on back of page if necessary). (NA, if not applicable). Judith Peters, PhD, BCIA

1 to 10	**Symptoms (Describe)**
________	**Handedness**: Right______ Left______ Ambidextrous _______
	ADD
	ADHD
	Alcohol or drug abuse
	Addictions-other
	Allergies
	Anorexia
	Anxiety
	Autism
	Asperger's Syndrome
	Auditory Processing problems
	Bedwetting
	Bipolar Disorder
	Bruxism / TMJ
	Cerebral Palsy
	Chronic fatigue
	Closed head injury
	Clumsiness (Right, Left, Upper, Lower)
	Death wish / Suicidal
	Depression
	Diabetes
	Difficulty expressing emotions
	Difficulty reading others' emotions
	Emotional Control problems
	Eating Disorder

Symptom Checklist: **Date** __________ **Name** ____________________________________

Rate each symptom on a scale of 1 to 10 (I0, is most severe). Describe when possible (write on back of page if necessary). (NA, if not applicable). Judith Peters, PhD, BCIA

1 to 10	Symptoms (Describe)
	Endocrine Disorders
	Episodic dyscontrol
	Excessive daytime sleepiness
	Fear
	Fibromyalgia or muscle pain or cramps
	Fine motor control
	Flashbacks
	Gross motor coordination problems
	Handwriting problem (Dysgraphia)
	Happiness level
	Hearing problems
	Impotence
	Impulsivity
	Incontinence (Urinary, Fecal)
	Lack of confidence
	Math difficulty
	Memory problems
	Menstrual / menopause problems
	Motility difficulty (walking, running kicking or balance problems)
	Multiple Sclerosis
	Multiple Personality Disorder
	Neurological Disorders
	Nightmares
	Numbness (which parts of body?)
	Obsessive Compulsive problems (OCD)
	Oppositional/Defiant

Symptom Checklist: **Date** ___________ **Name** _______________________________________

Rate each symptom on a scale of 1 to 10 (I0, is most severe). Describe when possible (write on back of page if necessary). (NA, if not applicable).

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1 to 10	**Symptoms (Describe)**
	Overeating
	Pain
	Parkinsonism
	Pervasive developmental disorder
	Poor Judgment
	Post-traumatic stress disorder
	Reactive attachment disorder
	Reading problems (Dyslexia)
	Recurrent thoughts
	Reward deficiency syndrome
	Seizure disorder
	Sensory integration problem
	Sexual addiction
	Sex offender
	Sexual Problems
	Sleep
	Snoring
	Spasticity (which parts of body?)
	Spatial relations problem
	Spelling difficulty
	Stiffness
	Stroke
	Tic disorder
	Tinnitus (ringing in ears)
	Tourette syndrome
	Toxic exposures

Updated January 2019

Symptom Checklist: **Date __________ Name ____________________________________**

Rate each symptom on a scale of 1 to 10 (I0, is most severe). Describe when possible (write on back of page if necessary). (NA, if not applicable). Judith Peters, PhD, BCIA

1 to 10	Symptoms (Describe)
	Tremor
	Verbal fluency problem
	Visual problems
	Vertigo or Nystagmus (Circle one)
	Visual processing problems
	Weakness (which parts of body?)
	Slow Mental Processing
	Other disorders (describe)

Medications, vitamins, herbs, or treatments/ therapy used currently?

OVERSENSITIVITY TO MEDS OR TREATMENTS? (Y/N)

What are the symptoms which most concern you and for which you are seeking relief?

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