Symptom Details

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_

Today's Date \_\_\_\_\_\_\_\_\_ Time \_\_\_\_\_\_ Diagnosis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Can you drive? Yes Sometimes No

Do you work or study? Yes Sometimes No

Do you have any close relationships? Yes I used to No

Please complete the list of symptoms below by indicating the frequency to which you feel each of them. Rate your symptoms from **0** (never) to **10** (always).

If either of your parents also had, or has, the symptom, please check the “Parent” column.

If the symptom came on suddenly, or has changed from how you used to be, please check

the “Change” column.

Frequency (0 - 10) Parent Change

**- Sensory -**

Are you sensitive to light? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Are your “smell” senses diminished or intensified? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Do you see speckles, spots, patterns, etc? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Do you hear whistles, pops, buzzing, etc? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Do you feel burning, itching, pain, tickles, etc? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

**- Emotions -**

Do you experience unexplained mood changes? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Do you have unexplained fearfulness? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Do you have unexplained spells of depression? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Do you have unexplained spells of elation? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Are you explosive? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Do you have suicidal thoughts or actions? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Frequency (0 - 10) Parent Change

**- Clarity -**

Do you ever feel “foggy”? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Do you have trouble following conversations? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Do you get confused? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Do you have trouble following what you read? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Do you have trouble concentrating? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Do you procrastinate and/or lack initiative? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Do you have trouble being attentive? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Do you have trouble sequencing? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Do you have trouble prioritizing? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Do you have trouble *not finishing* what you start? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Do you have trouble organizing spaces &/or things? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Do you cover-up *not knowing* what has been said? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

**- Energy -**

Do you lack stamina? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Are you fatigued during the day? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Do you have trouble falling asleep? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Do you have trouble staying asleep? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Do you have trouble falling back to sleep? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

**- Movement -**

Do you have any paralysis? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Do you get eye-strain fatigue? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Do you have double-vision? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Frequency (0 - 10) Parent Change

**- Pain -**

Does the outside of your head hurt? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Do you have throbbing head pain? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Do you have shoulder pain? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Do you have neck pain? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Do you have wrist pain? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Do you have tender muscle areas? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Do you have all-over pain? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Do you have joint pain? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Any other pain? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

**- Memory -**

Do you forget what you have just heard? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Do you forget what you’re doing or need to do? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Do you have trouble learning from experience? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

**- Activation / Anxiety -**

Do you get restless? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Do you get irritable? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Do you day dream? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Do you worry? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Are you always moving around? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Do you get cold hands and/or feet? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_

Do you get heart palpitations? \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_