ADULT BEHAVIOR CHECKLIST

Name:_____ Date:_____

Please circle **Y** = yes for behaviors that are a concern for you, **S** = sometimes for behaviors that are sometimes a concern for you and **N** = no for behaviors that are not a concern for you.

ATTENTION

When symptoms began (date)_____

Careless mistakes	Y	S	N
Poor attention span	Y	S	N
Trouble listening	Y	S	N
Trouble finishing tasks	Y	S	N
Problems organizing	Y	S	N
Avoid tasks requiring concentration	Y	S	N
Lose needed items	Y	S	N
Easily distracted	Y	S	N
Trouble remembering/forgetful	Y	S	N
Fidget, squirm	Y	S	N
On the go, seem driven	Y	S	N
Excessive restlessness	Y	S	N
Talk all the time	Y	S	N
Interrupt others	Y	S	N

MOOD

When symptoms began (date)_____

Weight change/appetite change	Y	S	N
Energy level change	Y	S	N
Sleep disturbance	Y	S	N
Difficulty concentrating	Y	S	N
Crying spells	Y	S	N
Loss of interest/pleasure	Y	S	N
Hopeless feelings	Y	S	N
Guilty feelings	Y	S	N
Isolate self	Y	S	N
Low self-esteem/self-hate	Y	S	N
Give things away	Y	S	N
Wish to be dead	Y	S	N
Injure self	Y	S	N
Think about death/violence often	Y	S	N
Rage outbursts	Y	S	N
Bizarre behavior, hallucinations	Y	S	N
Rapid, hard to follow speech/thoughts	Y	S	N
Think you are the smartest, best person in the world	Y	S	N

CONDUCT

When symptoms began (date)_____

Intimidate/threaten others	Y	S	N
Use of weapon	Y	S	N
Start fights	Y	S	N
Physically cruel to people/animals	Y	S	N
Forcibly stolen from victim	Y	S	N
Stolen without confronting victim	Y	S	N
Force sexual activity	Y	S	N
Deliberately set fires to cause damage	Y	S	N

ANXIETY/WORRY

When symptoms began(date)_____

Worry something terrible will happen to self/others	Y	S	N
Frequently refuse or are reluctant to go somewhere	Y	S	N
Avoid being alone	Y	S	N
Fear of going to sleep without someone else near	Y	S	N
Fearfulness of new situations, people or objects	Y	S	N
Engage in repeated behaviors (counting, cleaning, organizing, hand washing, etc,) or rigid rituals	Y	S	N
Excessive worry about everyday things	Y	S	N
Excessive nervousness for no reason	Y	S	N
Flashbacks/Nightmares	Y	S	N
Numbness	Y	S	N
Feeling disconnected	Y	S	N
Difficulty remembering/memory lapses	Y	S	N

Further comments about any of the above:_____

_____

_____

_____

YOUR STRENGTHS:

In work setting:_____

_____

In social setting:_____

_____

In home setting:_____

_____

Special Interests/Hobbies:_____

_____