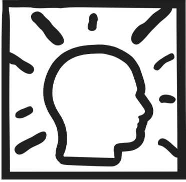

Sloan Gorman, LCSW
SloanGorman@gmail.com
707-789-7894
License #77773

Name:____

Date: ____

Symptom Frequency Scales

How often have you experienced the following symptoms over the last two weeks?

Depression	Not At All					Sometimes					All The Time	Drug Related
Feelings of sadness	0	1	2	3	4	5	6	7	8	9	10	
Difficulty falling asleep or staying asleep	0	1	2	3	4	5	6	7	8	9	10	
Desire to spend a lot of time sleeping	0	1	2	3	4	5	6	7	8	9	10	
Fatigue or loss of energy	0	1	2	3	4	5	6	7	8	9	10	
No interest in activities you used to enjoy	0	1	2	3	4	5	6	7	8	9	10	
Feelings of hopelessness	0	1	2	3	4	5	6	7	8	9	10	
Feelings of worthlessness	0	1	2	3	4	5	6	7	8	9	10	
Feelings of excessive and/or inappropriate guilt	0	1	2	3	4	5	6	7	8	9	10	
Impaired ability to concentrate	0	1	2	3	4	5	6	7	8	9	10	
Indecisiveness	0	1	2	3	4	5	6	7	8	9	10	
Excessive appetite OR poor appetite	0	1	2	3	4	5	6	7	8	9	10	
Feelings of restlessness	0	1	2	3	4	5	6	7	8	9	10	
Sense of moving slowly	0	1	2	3	4	5	6	7	8	9	10	
Thoughts of death	0	1	2	3	4	5	6	7	8	9	10	
Thoughts of suicide	0	1	2	3	4	5	6	7	8	9	10	
Unplanned weight gain OR weight loss	NO		YES		If so, HOW MUCH:							

Anxiety	Not At All					Sometimes					All The Time	Drug Related
Inability to relax	0	1	2	3	4	5	6	7	8	9	10	
Nervousness	0	1	2	3	4	5	6	7	8	9	10	
Numbness or tingling	0	1	2	3	4	5	6	7	8	9	10	
Heart pounding or racing	0	1	2	3	4	5	6	7	8	9	10	
Indigestion or discomfort in the abdomen	0	1	2	3	4	5	6	7	8	9	10	
Feelings of choking	0	1	2	3	4	5	6	7	8	9	10	
Shaky	0	1	2	3	4	5	6	7	8	9	10	
Scared	0	1	2	3	4	5	6	7	8	9	10	
Difficulty breathing	0	1	2	3	4	5	6	7	8	9	10	
Racing thoughts	0	1	2	3	4	5	6	7	8	9	10	
Sweating (not due to heat)	0	1	2	3	4	5	6	7	8	9	10	
Dizziness or lightheaded	0	1	2	3	4	5	6	7	8	9	10	
Fear of the worst happening	0	1	2	3	4	5	6	7	8	9	10	
Fear of losing control	0	1	2	3	4	5	6	7	8	9	10	
Fear of dying	0	1	2	3	4	5	6	7	8	9	10	