Symptom Assessment Checklist

Patient Name: _____ Date: _____

RATE SYMPTOM(S) OVER THE PAST WEEK:

Symptom Rating:

0 = Absent 1 = Present/not problematic 2 = Problematic/no impairment 3 = Problematic/with impairment

SYMPTOM	0	1	2	3	SYMPTOM	0	1	2	3	SYMPTOM	0	1	2	3
Headache					Stomach pain					Constipation				
Drowsiness					Blurred vision					Urination problems				
Weak/tired					Dry mouth					Sleep problems				
Sweating					Nervous/tense					Dizziness				
Nausea					Skin rash					Decreased interest in sex				
Weight gain					Diarrhea					Erectile problems				
Acne					Confusion/ reduced or lack of concentration					Absent or delayed orgasm/ejaculation				
Unsteadiness					Other:									

NOTES:

_____

_____

_____

_____

_____

_____

_____