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## Symptom Status Report

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Please rate any symptoms that you presently experience, indicating their relative severity since your last report. *If a symptom is new, circle it. If a symptom has gone away, draw a line through it. For symptoms that have continued, use a "B" for better, a "W" for worse, and "NC" for no change. Leave blank any symptoms that do not apply.*

**Circle = New    Line through = Gone    B = Better    W = Worse    NC = No Change**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Ability in tasks requiring steps     | <input type="checkbox"/> Fatigue - chronic         | <input type="checkbox"/> Skin crawling sensation |
| <input type="checkbox"/> Clear thinking                       | <input type="checkbox"/> Agitation                 | <input type="checkbox"/> Tinnitus                |
| <input type="checkbox"/> Confused thinking                    | <input type="checkbox"/> Anxiety                   | <input type="checkbox"/> Trouble going to sleep  |
| <input type="checkbox"/> Attention/concentration              | <input type="checkbox"/> Bed wetting               | <input type="checkbox"/> Trouble staying asleep  |
| <input type="checkbox"/> Reaction time                        | <input type="checkbox"/> Compulsive behaviors      | <input type="checkbox"/> Sleep apnea             |
| <input type="checkbox"/> Organization                         | <input type="checkbox"/> Tics                      | <input type="checkbox"/> Sleep - restlessness    |
| <input type="checkbox"/> Spaciness/foginess                   | <input type="checkbox"/> Mood swings               | <input type="checkbox"/> Sleep - talking         |
| <input type="checkbox"/> Forgetfulness                        | <input type="checkbox"/> Headaches                 | <input type="checkbox"/> Snoring                 |
| <input type="checkbox"/> Can't slow down                      | <input type="checkbox"/> Loss of emotional control | <input type="checkbox"/> Nightmares              |
| <input type="checkbox"/> Punctuality                          | <input type="checkbox"/> Obsessive thoughts        | <input type="checkbox"/> Night terrors           |
| <input type="checkbox"/> Hyperactivity                        | <input type="checkbox"/> Negative thoughts         | <input type="checkbox"/> Dream awareness         |
| <input type="checkbox"/> Racing thoughts                      | <input type="checkbox"/> Addictive behaviors       |  |
| <input type="checkbox"/> Talkativeness                        | <input type="checkbox"/> Eating habits             | Other symptoms/comments:                         |
| <input type="checkbox"/> Hyperfocus (over focused)            | <input type="checkbox"/> Nausea                    | _____  |
| <input type="checkbox"/> Impulsiveness                        | <input type="checkbox"/> Stomach aches             | _____  |
| <input type="checkbox"/> Aggressiveness                       | <input type="checkbox"/> Memory                    | _____  |
| <input type="checkbox"/> Happiness                            | <input type="checkbox"/> Reading                   | _____  |
| <input type="checkbox"/> Irritability                         | <input type="checkbox"/> Writing ability           | _____  |
| <input type="checkbox"/> Frustration                          | <input type="checkbox"/> Eye contact with others   | _____  |
| <input type="checkbox"/> Anger                                | <input type="checkbox"/> Empathy for others        | _____  |
| <input type="checkbox"/> Feeling blue                         | <input type="checkbox"/> Separation anxiety        | _____  |
| <input type="checkbox"/> Depression                           | <input type="checkbox"/> Oppositional behavior     | _____  |
| <input type="checkbox"/> Cries easily                         | <input type="checkbox"/> Lying                     | _____  |
| <input type="checkbox"/> Guilt/remorse - appropriate feelings | <input type="checkbox"/> Allergies                 | _____  |
| <input type="checkbox"/> Motivation                           | <input type="checkbox"/> Asthma                    | _____  |
| <input type="checkbox"/> Fears                                | <input type="checkbox"/> Body tension              | _____  |
| <input type="checkbox"/> Feeling jumpy                        | <input type="checkbox"/> Body awareness            | _____  |
| <input type="checkbox"/> Feeling or acting drunk              | <input type="checkbox"/> Bruxism (grinding teeth)  | _____  |
| <input type="checkbox"/> "Having your act together"           | <input type="checkbox"/> Heat sensitivity          | _____  |
| <input type="checkbox"/> Feeling calm/relaxed                 | <input type="checkbox"/> Cold sensitivity          |  |
| <input type="checkbox"/> Voice calmer or lower                | <input type="checkbox"/> Pain awareness            |  |
| <input type="checkbox"/> Feeling dull                         | <input type="checkbox"/> Pain - chronic            |  |
| <input type="checkbox"/> Energy                               | <input type="checkbox"/> Pain tolerance - high     |  |
|   | <input type="checkbox"/> Pain tolerance - low      |  |

For more detailed explanation, use back of paper.