The Brain Wellness Program

Basic Symptom Questionnaire and Reassessment Form

Name: ______________________ Date:__________

For each symptom below, check the box that best describes the degree to which you experience it most of the time.

Symptom	Absent	Slight	Mild	Moderate	Excessive	Severe
Depression						
Moodiness						
Unexplained						
Situational						
Fuzzy thinking (Inability to focus and concentrate)						
Anxiety/Worry (Obsessiveness, rumination)						
Carbohydrate/other food cravings						
Bread/pasta						
Sugar (treats, sodas & junk food)						
Irritability (overall)						
Unexplained						
Situational						
Number of hours of sleep per night: _________			Bedtime: _________		Wakeup Time: _________	
Insomnia						
Getting to sleep	Weekday time: _________			Weekend time: _________		
Difficulty staying asleep						
Waking too early	Time: _______		Are you able to fall back asleep? YES / NO			Time: _______
Headaches						
Unexplained						
Situational						
Fatigue/lack of energy						
Stressed/burned out						
Negativity						
Paranoia/hypervigilance						