

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						