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NAME _____ DATE _____

Please check **all** symptoms/problems you have experienced in the last 2 weeks.

___ depressed mood most of the day
- ___ less interest in your normal activities nearly every day
- ___ sleep problems (e.g., can't fall asleep, can't stay asleep, sleepy all the time)
- ___ low energy nearly every day
- ___ problems concentrating and/or making decisions
- ___ frequent thoughts of death and/or suicide
- ___ poor appetite or over-eating
- ___ low self esteem
- ___ hopelessness

___ abnormally elevated mood and/or irritable mood
- ___ inflated self esteem
- ___ more talkative than usual
- ___ high energy level
- ___ agitation
- ___ racing thoughts
- ___ less need for sleep (e.g., feeling rested & full of energy on just 3 hours' sleep)

___ mood swings for no known reason

___ intense fear or discomfort which starts abruptly & reaches a peak within a few minutes
- ___ pounding heart or faster heart rate than normal
- ___ shaking or trembling
- ___ dizziness or feeling light-headed or faint
- ___ feeling smothered, or shortness of breath, or feeling as if you are suffocating
- ___ fear of losing control, or feeling that you are "going crazy," or that you are dying

___ anxiety about being someplace that would be difficult to get out of quickly

___ persistent fear of a specific object or situation (e.g., flying, heights, blood, public speaking)
- ___ this fear occurs when faced with the specific object/situation or you anticipate facing it
- ___ you realize this fear is excessive and/or irrational and/or unreasonable
- ___ this fear causes significant interference in your usual daily activities

___ recurring, persistent thoughts that you can't get rid of
- ___ these persistent thoughts disturb you, and/or interfere with your daily activities
- ___ your efforts to get rid of these thoughts have been unsuccessful
- ___ these persistent thoughts disrupt your daily routine and/or work and are time consuming

___ repetitive behaviors that you feel driven to keep doing (e.g., checking things, counting)
- ___ you keep engaging in these physical or mental behaviors even though they seem irrational
- ___ these persistent behaviors disrupt your daily routine and/or work and are time consuming
- ___ your efforts to stop engaging in these behaviors have been unsuccessful
- ___ these persistent behaviors cause distress or anxiety

___ you experienced or saw something involving death, or which threatened death or serious injury to you and/or others
- ___ you have persistent memories, thoughts, dreams or images of the event(s)
- ___ you keep feeling as if this traumatic event keeps recurring (e.g., flashbacks)
- ___ you attempt to avoid thoughts, feelings, conversations about the event/trauma
- ___ you feel detached from others
- ___ your have less interest in your usual activities, or in activities you might otherwise engage in
- ___ difficulty falling asleep or staying asleep
- ___ irritability or outbursts of anger
- ___ problems concentrating
- ___ easily startled

NAME _____ DATE _____

___ excessive anxiety or worry about a number of things
- ___ difficulty controlling this worrying
- ___ restlessness
- ___ irritability
- ___ muscle tension (or maybe others have told you that your muscles were tense)
- ___ difficulty concentrating
- ___ sleep difficulties
- ___ physical symptoms or complaints for which you have sought treatment
- ___ these physical symptoms or complaints cause significant impairment in key areas of your life
- ___ history of pain in different places in your body, or related to different functions of your body
- ___ appropriate workup can't fully explain your problems or says your problems are exaggerated
- ___ the specific physical problem is pain in at least one place in your body
  - ___ this pain causes significant distress or impairment in at least one key area of your life
- ___ preoccupation with your appearance, and/or a defect in your appearance which causes significant distress or impairment in at least one key area of your life

___ sexual problems
- ___ persistent lack of desire for sexual activity, or persistent lack of sexual fantasies
- ___ aversion to sexual activity
- ___ persistent or recurrent inability to attain or to maintain sexual arousal
- ___ recurrent delay, or absence of, orgasm following a normal sexual excitement phase
- ___ recurrent ejaculation with minimal sexual stimulation (before you desire ejaculation)
- ___ recurrent genital pain associated with sexual intercourse
- ___ this sexual problem causes significant distress or interpersonal difficulty

___ problems with eating and/or food
- ___ intense fear of gaining weight or of becoming fat
- ___ worry about body weight and/or your body's shape
- ___ how you feel about yourself as a person depends on your body size and/or body weight
- ___ absence of at least 3 consecutive menstrual cycles (not due to surgery, menopause, etc.)
- ___ recurrent binge eating
- ___ feeling a lack of control during the binge eating
- ___ recurrent compensatory behavior after binge eating (e.g., self-induced vomiting, enemas . . .)

___ problems with sleep without depression, anxiety or other significant problem in your life
- ___ difficulty falling asleep or staying asleep, or non-restful sleep
- ___ excessive sleepiness (sleeping much longer than usual, daytime sleep periods)
- ___ sleep problems cause significant distress or disruption in your life
- ___ irresistible attacks of refreshing sleep daily
- ___ sleep disruption due to breathing problem during sleep

___ problems with impulse control
- ___ sudden episodes of explosive behavior (assaults, destroying property)
- ___ recurrent theft of objects not needed for personal use or their monetary value
- ___ deliberately setting fires
- ___ persistent maladaptive gambling
- ___ frequently pulling out lots of your own hair

___ problems with attention and/or hyperactivity
- ___ problems maintaining attention, making careless mistakes
- ___ failure to listen to others and/or to instructions
- ___ difficulty organizing tasks, activities
- ___ avoiding or reluctant to engage in activities that require sustained attention
- ___ often forgetful in daily activities
- ___ excessive fidgeting
- ___ difficulty staying still or staying quiet
- ___ difficulty waiting your turn and/or interrupting others and/or intruding on others

NAME _____ DATE _____

Do you consume products containing alcohol? Yes ___ No ___
If yes, what products do you typically consume? How often?

Do you use drugs/substances (including tobacco products) for recreational purposes? Yes ___ No ___
If yes, what do you use? How often?

Do you consume products containing caffeine (coffee, tea, soda, other products)? Yes ___ No ___
If yes, what types of products do you use? How often?

Do you have any thoughts of harming yourself or of ending your life? Yes ___ No ___
Please explain:

Have you ever had any thoughts of harming yourself or of ending your life? Yes ___ No ___
Please explain:

Do you own any guns and/or have access to guns? Yes ___ No ___
Please explain:

Do you experience any symptoms not mentioned in this form? Yes ___ No ___
Please explain: