Name: _____ Today's Date:_____ Please complete this questionnaire before your visit.

In general, how are you feeling? □ Better □Same □Worse- please explain: _____

On the rating scale below, CIRCLE the level of each symptom (ex): 1 2 3 4 (5) 6 7 8 9 10

Mild - Moderate - Severe

Have you been feeling…?	*Check the symptoms you currently have:*		
Depressed? ☐ Better ☐Same ☐ Worse ☐ No Symptoms **Rating Scale:** 1 2 3 4 5 6 7 8 9 10 ☐ Daily ☐ Few days/week ☐ Occasionally	☐ Sad most of the time ☐ Less interest in activities/hobbies ☐ Decreased appetite ☐ Increased appetite ☐ Sleeping More	☐ Sleeping less ☐ Fatigue/Tiredness ☐ Lack of Energy ☐ Hopelessness ☐ Worthlessness	☐ Feelings of guilt ☐ Trouble concentrating/thinking ☐ Thinking about death ☐ Suicidal Thoughts
Manic? ☐ Better ☐Same ☐Worse ☐No Symptoms **Rating Scale:** 1 2 3 4 5 6 7 8 9 10 ☐Daily☐ Few days/week☐ Occasionally	☐ Inflated self-esteem ☐ Decreased need for sleep ☐ More talkative ☐ Racing thoughts	☐ Distracted ☐ Increase in activity ☐ Increase in reckless/risky behavior ☐ Spending too much $$	
Psychotic? ☐ Better☐ Same☐ Worse☐ No Symptoms **Rating Scale:** 1 2 3 4 5 6 7 8 9 10 ☐ Daily ☐ Few days/week ☐ Occasionally	☐ Difficult thinking/understanding ☐ Disorientation ☐ Racing Thoughts ☐ Paranoia ☐ Thought disorder	☐ Unwanted Thoughts ☐ Hearing Voices ☐ Delusions ☐ Unusual Behaviors ☐ Inappropriate Behaviors	☐ Visual Hallucinations ☐ Incoherent Speech ☐ Rapid Speech ☐ Disorganized Speech ☐ No Emotion
Anxious? ☐ Better ☐Same☐ Worse☐ No Symptoms **Rating Scale:** 1 2 3 4 5 6 7 8 9 10 ☐Daily☐ Few days/week☐ Occasionally	☐ Excessive worry ☐ Restlessness ☐ Easily Fatigued ☐ Blank Mind/Difficulty Concentrating	☐ Irritability ☐ Muscle Tension ☐ Difficulty sleeping	
Social Anxiety? ☐ Better☐ Same☐ Worse ☐No Symptoms **Rating Scale:** 1 2 3 4 5 6 7 8 9 10 ☐Daily☐ Few days/week☐ Occasionally	☐ Fear of social situations ☐ Fear of embarrassment ☐ Fear of humiliation ☐ Social situations cause anxiety/panic	☐ Avoids social situations	
Panic Attacks? ☐ Better ☐ Same ☐ Worse☐ No Symptoms **Rating Scale:** 1 2 3 4 5 6 7 8 9 10 ☐Daily☐ Few days/week☐ Occasionally	☐ Palpitations/ heart racing ☐ Sweating ☐ Trembling/shaking ☐ Nausea/Vomiting	☐ Shortness of breath ☐ Feeling of choking ☐ Chest pain/discomfort ☐ Hot/Cold Flashes	☐ Dizziness ☐ Fear of losing control ☐ Fear of dying
Traumatic stress? ☐Better☐ Same ☐Worse☐ No Symptoms **Rating Scale:** 1 2 3 4 5 6 7 8 9 10 ☐Daily☐ Few days/week☐ Occasionally	☐ Ongoing recollections ☐ Distressing dreams ☐ Acting/feeling event again ☐ Distress to seeing resemblances ☐ Attempts to avoid reminders of event	☐ Attempts to avoid thoughts ☐ Attempts to avoid reminders ☐ Neg. beliefs of self/others/world ☐ Difficulty feeling happy ☐ Reckless Behavior	☐ Less interest ☐ Feeling detached ☐ Startled Responses ☐ Hypervigilant ☐ Irritability/Anger
Focusing Issues? ☐Better☐ Same ☐Worse ☐ No Symptoms **Rating Scale:** 1 2 3 4 5 6 7 8 9 10 ☐Daily☐ Few days/week☐ Occasionally	☐ Lack of attention to detail ☐ Doesn't listen when spoken to ☐ Not finishing tasks ☐ Disorganized ☐ Avoids tedious tasks	☐ Loses things ☐ Easily distracted ☐ Forgetful ☐ Fidgets/Squirms ☐ Unable to play quietly	☐ Often "on the go" ☐ Talks excessively ☐ Blurts out answers ☐ Difficulty waiting turn ☐ Interrupts others
Behavior Issues? ☐ Better ☐Same☐ Worse☐ No Symptoms **Rating Scale:** 1 2 3 4 5 6 7 8 9 10 ☐Daily☐ Few days/week☐ Occasionally	☐ Loses Temper ☐ Argues w/ Adults ☐ Defiant ☐ Annoys Others	☐ Blames Others ☐ Easily Annoyed ☐ Angry/Resentful ☐ Spiteful/Vindictive	
Aggressive? ☐Better ☐ Same☐Worse ☐ No Symptoms **Rating Scale:** 1 2 3 4 5 6 7 8 9 10 ☐Daily☐ Few days/week☐ Occasionally	☐ Severe temper ☐ Temper outbursts ☐ Frequently Irritated ☐ Verbal Aggression ☐ Physical Aggression	☐ Property Destruction ☐ Hitting ☐ Kicking ☐ Biting ☐ Throwing Objects	☐ Explosive Anger ☐ Easily Triggered ☐ Frequently angry

Taking Medication regularly? □ Yes □ Irregular □ Stopped □ Refused

Medication Side Effects: _____

Sleep: □ Good □ Difficulty falling □ Difficulty staying □ Early wakening □ Excessive sleep

Recent Stressors: □ Employment □ Relationship □ Grief/Loss □ Physical Health □ Financial □ Other: _____

Thoughts of harming self? □Yes □No If YES, since last visit? □Yes □No

Thoughts of harming others? □Yes □No If YES, since last visit? □ Yes □ No

Office Use Only: □ C-SSRS □ New □ 120

Staff Signature: _____