

Name \_\_\_\_\_

Client ID \_\_\_\_\_

Date \_\_\_\_\_

Note if Clinician Administered, by Whom \_\_\_\_\_

## Symptom Screening Form

Many people in our programs have various symptoms and problems. For us to better serve you, please answer the questions on these pages. Place a check (✓) in the box to the right of each question to show how much this type of feeling has been bothering you for the last several days.

		0 Not at all	1 Rarely	2 Some- times	3 A Lot
<b>D</b>	1. Have you been feeling sad or blue?				
	2. Does your future seem lonely or hopeless?				
	3. Do you feel worthless or not as good as other people?				
	4. Have you lost interest in activities you used to enjoy?				
	5. Do you feel life is not worth living or you're better off dead?				
<b>A</b>	6. Do you feel nervous, shaky, tense, or restless inside?				
	7. Do you feel afraid?				
	8. Do you worry a lot?				
	9. Do you have physical stress—tense muscles, headaches, trouble breathing, or upset stomach?				
<b>P</b>	10. Do you hear voices other people say they don't hear?				
	11. Do you believe others are against you or are watching you?				
	12. Do you feel out of touch with other people or not close to them?				
	13. Do you feel someone or something else controls you or your thoughts?				
<b>H</b>	15. Do you feel easily irritated or lose your temper?				
	16. Do you feel like breaking or smashing things?				
	17. Do you think about hurting other people?				
	18. Do you hit or injure people?				
<b>T</b>	19. Do you ever have bad dreams or thoughts about troubling or harmful events that happened to you in the past?				
	20. Are you jumpy or easily startled by noises or movements?				
	21. Do you have periods of time in your life that you can't remember?				
	22. Have you ever been through an event that involved a physical threat or harmed you?				
	23. Do you ever feel numb, apart, or without much feeling at all?				
<b>E</b>	24. Do you or have you ever eaten a very large amount of food within 2 hours?				
	25. Have you worried about gaining weight or being fat even if you were underweight?				
<b>M</b>	26. Do you have intense mood ups-and-downs?				
	27. Do your thoughts seem to race, or do you feel too active?				
	28. Do you ever go without sleep, sometimes even for a few days?				
	29. Do you do things without thinking about what will happen?				

## Symptom Screening Form Scoring Sheet

<u>Client Name</u>	<u>Client ID #</u>	<u>Date of 1<sup>st</sup> screening</u>	<u>Date of 2<sup>nd</sup> screening</u>
<u>Section</u>	<u>1<sup>st</sup> score</u>	<u>2<sup>nd</sup> score</u>	<u>Instruction</u>
Question 5 score	_____	_____	***If 1 or more, immediately do a suicide assessment and discuss with supervisor for possible emergency psychiatric evaluation.***
Question 18 score	_____	_____	*** If 1 or more, immediately discuss with supervisor for possible mental health referral.***
<p><b>For the scores below, if the score is as indicated or higher in one of the items, discuss with supervisor and consider mental health referral.</b></p>			
Depression section	_____	_____	If 6 or more, discuss...
Anxiety section	_____	_____	If 6 or more, discuss...
Psychotic section	_____	_____	If 4 or more, discuss...
Hostility section	_____	_____	If 3 or more, discuss...
Trauma section	_____	_____	If 3 or more, discuss...
Eating disorders section	_____	_____	If 3 or more, discuss...
Manic section	_____	_____	If 5 or more, discuss...