BRIEF PSYCHIATRIC SCREEN- ADULT ©

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NAME: .... DATE: .... AGE: ....

CURRENT MARITAL STATUS: .... # OF PAST MARRIAGES: ....

HIGHEST EDUCATION LEVEL: .... OCCUPATION: ....

JOBS IN LAST 10 YEARS: .... LONGEST TIME ANY JOB WAS HELD: ....

CURRENT LEGAL ISSUES: ....

REASONS FOR NOW SEEKING PSYCHIATRIC CONSULTATION

1.) What ONE problem are you MOST worried about today (that brings you here)?

....

2.) When was the last time you felt mentally/emotionally well?

....

3.) When did you FIRST become concerned about this?

....

4.) WHOSE idea was it to come in to see a psychiatrist?

....

5.) How do you feel we could be most helpful TODAY for your needs?

....

PAST MENTAL HEALTH EXPERIENCE

YES **NO** 1.) Have you ever been treated for psychiatric, mental, or emotional problems before?

YES **NO** 2.) Have you ever been treated for alcohol or drug problems (including AA and NA)?

3.) If **YES** to either question, please fill in **below**:

Date	Inpat./Outpat.	Hospital/Location	Diagnoses
____________	___________	__________________________________	___________________________
____________	___________	__________________________________	___________________________
____________	___________	__________________________________	___________________________
____________	___________	__________________________________	___________________________

Estimated lifetime number of psychiatric hospitalizations: _____________________________

Estimated time in outpatient psychiatric/mental health care (in months or years): ___________________

Estimated percentage of adult lifetime ill/incapacitated: _____________________________

Longest hospitalization: _____________________________

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PAST MEDICAL EXPERIENCE

YES **NO** 1.) Are you currently being treated for any medical problems?

YES **NO** 2.) Are you aware of any medical problems that you should be treated for?

YES **NO** 3.) Have you have significant medical illness/surgery in the past?

4.) If yes to either question, please fill in the **below.**

Date	Inpat./Outpat.	Hospital/Location	Diagnoses
_________	__________	__________________________________	______________________
_________	__________	__________________________________	______________________
_________	__________	__________________________________	______________________
_________	__________	__________________________________	______________________
_________	__________	__________________________________	______________________

CURRENT MEDICATIONS

Name	Strength	How Many Times a Day?	How Long Taking It?
_____________________________	_________	__________________	___________________
_____________________________	_________	__________________	___________________
_____________________________	_________	__________________	___________________
_____________________________	_________	__________________	___________________
_____________________________	_________	__________________	___________________
_____________________________	_________	__________________	___________________
_____________________________	_________	__________________	___________________

PAST PSYCHIATRIC MEDICATIONS

Name	Strength	How Many Times a Day?	How Long Taking It?
_____________________________	_________	_________________	___________________
_____________________________	_________	_________________	___________________
_____________________________	_________	_________________	___________________
_____________________________	_________	_________________	___________________
_____________________________	_________	_________________	___________________
_____________________________	_________	_________________	___________________
_____________________________	_________	_________________	___________________
_____________________________	_________	_________________	___________________
_____________________________	_________	_________________	___________________

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PERSONAL TRAUMA HISTORY

YES **NO** Have you ever been the victim of physical, emotional, or sexual abuse?

If **YES**, please BRIEFLY describe with approximate dates/ages:

____

____

____

____

FAMILY PSYCHIATRIC HISTORY

YES **NO** Has anyone in your family (**blood relatives**) received mental health services (hospitalization, outpatient counseling or psychiatric visits, substance abuse treatment), had a “nervous breakdown,” or attempted/committed suicide?

Relationship	Probable Diagnosis	Medication(s) Used
____________	________________________	______________________
____________	________________________	______________________
____________	________________________	______________________
____________	________________________	______________________

PERSONAL HABITS

1.) Do you take any herbal preparations or special vitamins/nutritional supplements? If **YES**, describe:

____

2.) Number of caffeinated drinks per day: ___________ Type: __________________________________

3.) **Do** you (or **did** you) smoke? If **YES**, estimated packs-per-day: _________ For how many years? ________

4.) **Do** you (or **did** you) drink alcoholic beverages? If **yes**, estimated amount of drinks per week: __________

5.) **Do** you (or **did** you) use illegal drugs? If **YES**, please fill out below:

Type/Name:	Amount or $ per week:	When began:	Last Use:
__________________	________________	____________	________________
__________________	________________	____________	________________
__________________	________________	____________	________________
__________________	________________	____________	________________
__________________	________________	____________	________________

PERSONAL SYMPTOM HISTORY

SECTION ONE Think back to the **past week (7 days)**

YES **NO** For the last week have you felt unusually good, confident, energetic, “hyper,” or “on top of the world”?

YES **NO** During the last week have you felt more easily angered, more short-tempered, more irritable than usual, perhaps arguing more or getting involved in fights or shouting more?

YES **NO** During the last week have you needed less sleep than normal, perhaps feeling rested and energetic with only 2 or 3 hours of sleep a night?

YES **NO** During the last week have you been talking more than normal, talking faster than usual, having others complain that they can't get a word in edgewise or can't understand you very well?

YES **NO** During the last week have your thoughts been racing or jumping from one idea or topic to another faster than you could keep track of?

YES **NO** During the last week has it been difficult for you to focus on one thing at a time, so much so that little things seem to distract you?

YES **NO** During the last week has your activity level increased, so that you are more busy than usual, working harder, making new plans, socializing or playing more, or having more sexual activity than usual?

YES **NO** During the last week have you been more impulsive than usual, doing things that are uncharacteristic of you or that are more risky than usual, such as driving too fast or recklessly, spending too much money, illegal or immoral activities, etc.?

Overall, how disabling have the **above** symptoms been? (0= not at all, 5 = notable, 10 = completely disabling):

0 1 2 3 4 5 6 7 8 9 10

YES **NO** HAS THERE BEEN ANY **PAST** TIMES IN YOUR LIFE WHEN SEVERAL OF THE ABOVE SYMPTOMS EXISTED TOGETHER FOR A **CONTINUOUS PERIOD OF ONE WEEK OR MORE**?

SECTION TWO Think back to the **past 2 weeks (14 days)**

YES **NO** During the last two weeks, for most of the time have you been feeling more sad, down, blue, depressed or moody than usual?

YES **NO** During the last two weeks have you felt more easily angered, more short-tempered, more irritable than usual, perhaps arguing more or shouting more?

YES **NO** During the last two weeks have you lost your usual interest in activities you typically enjoy, such as hobbies, work, TV, reading, sports, socializing?

YES **NO** During the last two weeks have you had a change in your appetite? Have you lost or gained weight without dieting?

YES **NO** During the last two weeks have you had trouble falling asleep, staying asleep, sleeping restlessly, getting enough sleep, or even sleeping too much?

YES **NO** During the last two weeks have you lost energy, been more fatigued or tired than usual?

YES **NO** During the last two weeks have your thoughts been sped up or jumbled, have you been restless, fidgety, unable to sit still? Or have you been thinking, moving and talking more slowly than narmal?

YES **NO** During the last two weeks have you been feeling worthless or excessively guilty, more down on yourself or thinking negative thoughts about yourself?

YES **NO** During the last two weeks have you had trouble thinking or concentrating, trouble making decisions more so than usual?

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YES **NO** During the last two weeks have you had difficulty motivating yourself to go to work, school, or take care of your basic needs or family obligations?

YES **NO** During the last two weeks have you had thoughts of death, that life's not worth living, that you'd be better off dead, or of ending your own life?

YES **NO** Have you begun to make plans to end your own life, or even acted on those plans in a suicide attempt?

Overall, how disabling have the **above** symptoms been? (0= not at all, 5 = notable, 10 = completely disabling):

0 1 2 3 4 5 6 7 8 9 10

YES **NO** HAS THERE BEEN ANY **PAST** TIMES IN YOUR LIFE WHEN SEVERAL OF THE ABOVE SYMPTOMS EXISTED TOGETHER FOR A **CONTINUOUS PERIOD OF TWO WEEKS OR MORE**?

NOTE: If ***EITHER*** **SECTION ONE** or **SECTION TWO** applied to you, please answer the following 5 questions; if ***NEITHER*** **Section One** nor **Section Two** applied, **SKIP** to **SECTION FOUR** below.

SECTION THREE

During that period of time described above in **SECTIONS ONE AND TWO**, did any of the following occur:

YES **NO** Heard people talking or calling your name when nobody was around, or heard noises that others didn't hear?

YES **NO** Seen things that others couldn't see?

YES **NO** Felt very suspicious, like others were following you, watching or spying on you, plotting against you, or trying to poison you?

YES **NO** Thought that you had unusual powers or abilities, knowledge, talents or importance?

YES **NO** Thought that the TV, newspapers or radio was sending messages to you that only you could understand?

Overall, how disabling have the **above** symptoms been? (0= not at all, 5 = notable, 10 = completely disabling):

0 1 2 3 4 5 6 7 8 9 10

For the next 2 questions, think back over your **entire life:**

YES **NO** HAS THERE BEEN ANY TIME IN THE ***PAST*** WHEN MANY OF THE ABOVE SYMPTOMS FROM SECTIONS ONE, TWO AND THREE OCCURRED FOR A CONTINUOUS PERIOD OF TWO WEEKS OR MORE?

YES **NO** HAVE YOU EVER IN THE PAST BEGUN TO MAKE PLANS TO END YOUR OWN LIFE, OR EVEN ACTED ON THOSE PLANS IN A SUICIDE ATTEMPT?

If YES, when and how: ____

SECTION FOUR Now, think back to the **last month (30 days):**

YES **NO** Have you heard voices off and on that others did not hear?

What do they say? ____

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YES **NO** Have you felt very suspicious or paranoid, afraid that you were under surveillance, being followed, being poisoned, or that people were conspiring against you?

YES **NO** Have you thought your spouse is having an affair or cheating on you?
What evidence do you have? ____

YES **NO** Have you felt you had done some terrible thing, so that it constantly bothers your conscience and you feel that you need to be punished for it? What was it? ________________________

YES **NO** Have you noticed your thoughts were mixed up, scrambled, disorganized, or that they would suddenly cut off in mid-stream?

YES **NO** Have you sensed your thoughts were being taken away or put into your head by an outside person or group?

YES **NO** Have you had very strongly held ideas and beliefs that seemed so unusual or odd to other people that you hardly ever mention it anymore? As examples, firm beliefs like you are secretly married to an important person, that you are a powerful religious figure, that some people in the government are actually robots?

YES **NO** Have you felt that something very awful or disgusting was wrong with your body or your appearance, even though other people don't notice it?
What is it? ____

YES **NO** Have you had times where you walked into a room and thought people were talking about you or laughing at you? Have you seen things in newspaper or on TV that have special messages or meaning only for you?

YES **NO** Have people thought you were acting odd, where you froze up and didn't move or speak for hours, kind of like a statue?

YES **NO** Have you or other people noticed that it was difficult for you to start anything or get motivated to begin anything, so that you would sit and stare for long periods of time, not talking, not showing any emotion or facial expression?

YES **NO** Since these symptoms began, have you had more and more trouble doing the normal things in life, such as working, socializing, or taking care of your family or yourself?

Overall, how disabling have the **above** symptoms been? (0= not at all, 5 = notable, 10 = completely disabling):

0 1 2 3 4 5 6 7 8 9 10

YES **NO** HAVE THE **ABOVE** SYMPTOMS AND PROBLEMS GONE ON CONTINUOUSLY FOR SIX MONTHS OR MORE SINCE THEY BEGAN?

YES **NO** HAVE THE ABOVE SYMPTOMS AND PROBLEMS EVER OCCURRED IN THE PAST, BUT WENT AWAY? OR HAVE THEY BEEN ALWAYS PRESENT, BUT TEND TO COME AND GO OVER TIME?

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SECTION FIVE Think back to the **last month (30 days):**

YES **NO** During the last month have you had the experience where suddenly for no reason you felt very anxious and scared, afraid of going crazy, dying, or losing control?

YES **NO** If yes to the above, did the anxiety attack reach a peak in about 5 to 10 minutes and last less than 30 minutes overall?

During these attacks did you have any of the following symptoms at the same time:

__ Shortness of breath or smothering
__ Dizziness, unsteadiness, feeling faint
__ Heart races, skips a beat, or pounds
__ Trembling and shaking
__ Sweating
__ Confused thinking
__ Choking sensation
__ Nausea, feel like throwing up
__ Things around you seem unreal
__ Tingling or numbness
__ Hot flashes or chills
__ Chest pain or discomfort
__ Feeling detached from your body or surroundings
__ Afraid you might go crazy or lose control
__ Afraid you might die
__ Lump in throat

YES **NO** During the last month, have you had four or more of these anxiety attacks?

YES **NO** Have you spent a lot of time worrying about having another attack or even changed your daily habits to avoid setting off another attack?

YES **NO** Does it bother you to go outside your house or very familiar surroundings, or to be in crowded places like supermarkets and malls because of a fear that safety would not be close by, that something embarrassing or dangerous might happen and you might need help from strangers?

Overall, how disabling have the **above** symptoms been? (0= not at all, 5 = notable, 10 = completely disabling):
0 1 2 3 4 5 6 7 8 9 10

YES **NO** Are you bothered by thoughts, ideas, or images that come to mind that are unwanted and intrusive and don't seem rational, such as constantly being preoccupied and worried about dirt, germs, cleanliness, violence, orderliness, symmetry, sexual issues, etc. ?

Please describe: ____

YES **NO** Do you do things in a ritualized way or have certain mental rituals or routines that you feel you must do over and over (such as counting, repetitive hand washing, repeating certain phrases, etc.) in order to avoid bad consequences or even disaster ?

Please describe: ____

____

Overall, how disabling have the **above** symptoms been? (0= not at all, 5 = notable, 10 = completely disabling):
0 1 2 3 4 5 6 7 8 9 10

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YES **NO** Have you ever had a terrible event happened to you, during which you were afraid that you or others would die or be seriously injured or mutilated, and where you felt helpless and horrified? Please describe: ____

____

YES **NO** If YES, Do you relive this terrible experience by unwanted nightmares, flashbacks, intense panic when in situations that remind you of the event, even thinking at times you are actually re-experiencing the event, kind of like watching a movie?

YES **NO** Because of your trauma experience, do you find yourself always keyed up and on edge, detached from others emotionally, avoiding anything that reminds you of the traumatic experience?

YES **NO** Have all these above trauma-related troubles lasted less than one month?

Overall, how disabling have the **above** symptoms been? (0= not at all, 5 = notable, 10 = completely disabling):

0 1 2 3 4 5 6 7 8 9 10

Now, think back to the **last 6 months**:

YES **NO** During the last **six months or more**, have you constantly felt nervous or anxious, worrying a lot about many things that might happen, to the point that people consider you a "worry-wart?"

During the last six months or more, which of the following symptoms have you experienced all together when you were worrying?

__ Muscles feel tense, sore and achy
__ Feel restless, pacing, can't sit still
__ Heart races, skips a beat, or pounds
__ Trembling, twitching and shaking
__ Sweat a lot, have cold clammy skin
__ Short of breath, can't catch breath
__ Trouble swallowing, lump in throat
__ Feel wired, keyed-up, on edge
__ Trouble concentrating or mind goes blank
__ Nausea, stomach pain, diarrhea
__ Feel dizzy and lightheaded
__ Tingling or numbness
__ Hot flashes, flushing or chills
__ Chest pain or discomfort
__ Feeling detached from your body or surroundings
__ Sudden noises startle you
__ Frequent urination
__ Feel especially impatient and irritable
__ Trouble falling asleep or staying asleep
__ Afraid you might go crazy or lose control

Overall, how disabling have the **above** symptoms been? (0= not at all, 5 = notable, 10 = completely disabling):

0 1 2 3 4 5 6 7 8 9 10

YES **NO** Do you avoid being in crowds or social situations when you think others are observing, judging, or scrutinizing you?

YES **NO** Do you avoid these types of situations because they tend to cause extreme distress or even panic attacks?

YES **NO** Does your avoidance interfere with your work, promotions, friendships, or school activities?

Overall, how disabling have the **above** symptoms been? (0= not at all, 5 = notable, 10 = completely disabling):

0 1 2 3 4 5 6 7 8 9 10

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SECTION SIX

YES	**NO**	Do you find yourself struggling to keep your weight down, even below what others consider "normal" weight for you?
YES	**NO**	Are you very afraid of becoming fat even though your parents or your doctor says that you are actually underweight?
YES	**NO**	Do you see your weight and body shape as having problems, that there are still areas that feel too fat or not quite toned enough?
YES	**NO**	Do you not eat certain foods (particularly fatty foods) or even most food, go on strict diets or even fast for long periods, or exercise a lot to reduce your weight?
YES	**NO**	Do you feel a need to hide how much you diet or exercise from others?
YES	**NO**	Do you sometimes make yourself throw up or use laxatives, enemas or water-loss pills to remove excess weight?
YES	**NO**	(For women): Has there been any irregularities in your monthly cycle, or has it stopped completely?
YES	**NO**	Do you binge eat frequently, and feel a loss of control over how much you eat at times?
YES	**NO**	Has the binge eating been going on a few times a week, for at least 3 months?
		How much do you think you weigh now? .... How much would you like to weigh? ....

Overall, how troubling have the **above** symptoms been? (0= not at all, 5 = notable, 10 = completely disabling):

0 1 2 3 4 5 6 7 8 9 10

SECTION SEVEN

YES	**NO**	Have you recently had a few instances of being unable to resist your angry or aggressive urges, so that you ended up getting into fights, hurting others, or breaking things?
YES	**NO**	Looking back, does it seem to you (or even others) that your behavior was a bit out of proportion to whatever it was that set you off?
YES	**NO**	Have you had trouble resisting urges to steal things, not for any real reason or personal use?
YES	**NO**	Do you have a sense of building tension right before you steal something, and then feel pleasure/relief/or gratification after the theft?
YES	**NO**	Does the stealing seem senseless to you, that you are not doing it out of vengeance or anger or need for money?

Overall, how troubling have the **above** symptoms been? (0= not at all, 5 = notable, 10 = completely disabling):

0 1 2 3 4 5 6 7 8 9 10

YES NO Have any of the above Sections of symptoms occurred **previously** in your life, but **now** are no longer a problem?

If yes, please note which Section applied to you: ____________________________

THANK YOU FOR YOUR HELP! PLEASE GIVE THIS TO YOUR DOCTOR.

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