

NAME _____

DATE _____

During the past week have you experienced?	Never or Rarely	Sometimes	Often	Very Often
Little interest of pleasure in doing things	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3
Trouble falling asleep or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself or that you are a failure or have let yourself or family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching TV	0	1	2	3
Moving or speaking so slowly that other people could have noticed. Or the opposite-being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3

Problems with getting work done inside or outside the home	0	1	2	3
Anxious feelings & behavior	0	1	2	3
Hearing voices	0	1	2	3
Your thoughts racing	0	1	2	3
Binging on food or starving yourself	0	1	2	3
Drinking too much alcohol or using drugs	0	1	2	3

Any stress related to: Immediate family Extended family A martial/significant relationship finances
 Parenting responsibilities medical condition housing issues friendships occupational conflicts

Since the last time you were here are you: Much better Little better No change Little worse Lot worse

Please list current psychiatric medications and dose taken daily:

Any side effects to medications: Rash Bruising Headache Shakes or Tremors Diarrhea Vomiting
 Weight Gain Seizures Slowed Thinking More Nervous Other

Are you taking your medication as prescribed on a daily basis: YES NO