

# QUICK SCREEN

## RATE YOUR SYMPTOMS OR YOUR CHILD'S SYMPTOMS SINCE LAST VISIT

**Please Rate ALL Symptoms - Rating Scale 0 = None 1 = Mild 2 = Moderate 3 = Severe**

Name \_\_\_\_\_ Date \_\_\_\_\_

	Sad mood		Loss of interest		Feeling bored	E
	Crying		Hearing voices		Feeling restless	
	Irritability		Appetite decreased		Decreased energy	
	Anger		Appetite increased		Feeling worthless	D
	Blow-ups		Difficulty going to sleep		Feeling guilty	
	Problems paying attention		Difficulty staying asleep		Feeling hopeless	
	Hard time making decisions		Waking early		Thoughts of suicide	
	Mood swings		Excessive sleep		Suicide plans	M

Comments \_\_\_\_\_

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	Making careless mistakes		Hard time with details		Hard time keeping focus	D
	Answering questions before question completed		Hard time with boring work or schoolwork		Forgetting things, i.e. keys appointments, homework	
	Easily distracted		Problems organizing		Losing things	
	Fidgety		Have to be on the go		Hard time sitting still	H
	Talking too much		Interrupting others		Not completing projects	D
	Hard time waiting (traffic, lines)		Talking too loudly		Restless inside	
	Difficulty listening		Hard time with instructions		Doing things impulsively	A

Comments \_\_\_\_\_

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	Big plans <input type="checkbox"/> Unrealistic plans <input type="checkbox"/>		Big mood changes		Very distracted	D
	Feeling extra good		Hearing voices		Thoughts racing	
	Spending sprees <input type="checkbox"/> Partying <input type="checkbox"/>		Getting by on little sleep		Talking fast	
	Driving fast		Feeling extra energetic		High sexual interest <input type="checkbox"/> Inappropriate <input type="checkbox"/>	
	Silly <input type="checkbox"/> Overly happy <input type="checkbox"/>		Many projects at once		Temper outbursts	
	Very irritable <input type="checkbox"/> Frustrated <input type="checkbox"/>		Interrupting others		Rage attacks	
	Extremely active ("hyper")		Have to talk a lot		Doing risky things	B

Comments \_\_\_\_\_

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	Bad dreams		Flashbacks		Thoughts about trauma	D
	Reliving trauma		Upsetting memories		Avoiding thinking about trauma	S
	Feeling bad if reminded of trauma		Pushing down thoughts of trauma		Hard time talking about trauma	T
	Feeling like trauma happening again		Problems remembering parts of trauma		Avoiding activities associated with trauma	P

Comments \_\_\_\_\_

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**RATE YOUR SYMPTOMS OR YOUR CHILD'S SYMPTOMS SINCE LAST VISIT**  
 Please Rate ALL Symptoms - Rating Scale 0 = None 1 = Mild 2 = Moderate 3 = Severe

Name \_\_\_\_\_ Date \_\_\_\_\_

Panic attacks	Rapid heart beat	Shortness of breath	D
Unexplained chills	Hot flashes	Fearing loss of control	
Super anxious	Feeling faint	Numb or tingly	P
Rapid onset of anxiety	Fear of social situations	Worried a lot	
Can't control worries	Problems with attention	Mouth dry	D
Hands cold and clammy	Muscle tension	Easily startled	A
Feeling on edge	Chest pains	Light headed	G

Comments \_\_\_\_\_

Disturbing thoughts	Senseless thoughts	Can't ignore thoughts	D
Doing things to prevent thoughts	Excessive washing	Excessive counting	C
Needing things in order	Excessive checking	Excessive praying	O
Can't stop doing things (Compulsions)	Can't stop thinking about things (Obsessions)	Having to do things because of thoughts	

Comments \_\_\_\_\_

Oppositional at times	Using drugs	Using alcohol	M
Hurting self	Feel people out to get me	Feel people trying to control me	Y
Cutting on self	Excessive eating	Feeling empty	S
Hitting people	Concerns about weight	Feeling evil or bad	N
Doing impulsive things	Feel people watching me	Getting off track	E
Feeling abandoned	Rarely feeling good	Basically unhappy	G
Feel people don't give back	Disappointed by relationships	Thoughts about hurting others	

Comments \_\_\_\_\_

**LIST THREE THINGS THAT CAUSE YOU OR YOUR CHILD THE MOST PROBLEMS SINCE THE LAST VISIT.**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**GENERAL ABILITY TO FUNCTION AND PERFORM**

RATE ON SCALE OF 1 TO 10

VERY POOR 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 VERY GOOD

<input type="checkbox"/> School or work	<input type="checkbox"/> Thinking clearly	<input type="checkbox"/> Feelings about self	<input type="checkbox"/> Exercise
<input type="checkbox"/> Getting along with others	<input type="checkbox"/> Having fun	<input type="checkbox"/> Handling emotions	<input type="checkbox"/> Diet
<input type="checkbox"/> Response to treatment	<input type="checkbox"/> Structure in life	<input type="checkbox"/> Feeling successful	<input type="checkbox"/> <b>OVERALL FUNCTIONING</b>