Patient Self-Report Screening Tool for Mental Illnesses

Patient Name: _____ Birthdate: _____

Questionnaire Date: _____

The following questions are meant as screening questions only. A positive answer does not confirm a diagnosis. Your physician will be conducting a more in-depth assessment; this screening tool is solely meant to help your physician focus on the most distressing symptoms.

DISORDER	QUESTION	YES	NO
1. Depression	Have you felt "down," most of the day, nearly every day, for the past 2 weeks?		
	In the past 2 weeks, have you been less interested in most things or less able to enjoy the things you used to enjoy most of the time?		
	Do you have low self-esteem or feelings of guilt?		
	In the past month, did you think that you would be better off dead or wished you were dead?		
2. Generalized Anxiety Disorder	Have you worried excessively, or been anxious, about several things with regard to day-to-day life while at work, at home, or in your close circle, which is out of proportion considering your life circumstances for at least the last 6 months? (If you answered "Yes," tell your health care provider what you worry about.)		
	Are you by nature a worrier or is this new for you?		
	Do you think you worry more than most other people?		
	Have you been unable to stop or control your worrying, or to let go of your worries, holding them inside?		
	In the last 6 months, have you been feeling physically unwell because of your worrying (feeling exhausted, having problems sleeping, getting headaches, having trouble focusing, having sore muscles)?		
	Do your worries get in the way of your day-to-day life at home, work, or when you are with friends?		
	On a scale of 0 to 10, how problematic is this for you?		

DISORDER	QUESTION	YES	NO
3. Panic Attacks	Have you had an unprovoked ("out of the blue") attack or spell during which you suddenly felt anxious, frightened, uncomfortable, or uneasy, even in situations in which most people would not feel this way?		
	Are the attacks of fear or panic so intense you had to do something to stop them or were so physically distressing you thought you might collapse or die?		
	Do these attacks peak quickly within minutes?		
	If you answered "Yes," describe to your health care provider what happens when you get these attacks.		
	Do you experience at least 4 of the following: palpitations, chest pains, chills, sweating, dizziness, hot flashes, or difficulty breathing during these spells?		
	How often do you get these attacks?		
4. Panic Disorder	After an attack, do you worry for at least 1 month about having another attack?		
	Are the attacks brought on by any triggers; for example, social situations?		
	Does this fear of having attacks prevent you from doing certain things or interfere with your life; for example, do you avoid the "panic" triggers (going to the mall or crowded places)?		
5. Agoraphobia	Do you feel anxious or particularly uneasy in places or situations from which you might find it difficult to leave or escape and where help might not be available (e.g., in a crowd, standing in line, when you are alone away from home or alone at home, or when crossing a bridge in a bus, train, or car)?		
	Do you fear these situations so much that you avoid them, suffer through them, or need a companion to face them?		
	Has this lasted more than 6 months for most days?		
	Is the anxiety out of proportion to the actual danger or threat in the situation?		
6. Social Anxiety Disorder	Do unfamiliar social situations cause you to feel anxious, distressed, or panicky?		
	Are you fearful of being humiliated or embarrassed in social situations or when you are "performing," such as speaking in public, being watched, or eating?		
	Are you uncomfortable or embarrassed at being the center of attention?		
	Do you blush, sweat, and/or tremble when speaking in public or in social situations such as eating or writing?		
	What types of social situations make you feel anxious or panicky (e.g., giving a speech, introducing yourself, talking in a group, eating in public, walking into a gathering of unfamiliar people, someone watching you do things such as writing)?		
	Are there things you avoid or activities that you cannot or will not do because of your worries or your fears?		

DISORDER	QUESTION	YES	NO
7. Obsessive-Compulsive Disorder	Are you experiencing intrusive or repetitive thoughts, images, or urges that you cannot stop; for example, thoughts of dirt, germs, or violent or disturbing sexual thoughts?		
	Do these thoughts cause you to do things repeatedly or compulsively, such as excessive washing or checking something until it feels right?		
	Do you believe that this will actually happen (e.g., if you do not keep washing your hands repeatedly, you will be full of germs, or your hands will not be clean)?		
	Do these thoughts interfere with your normal routine at home, work, school, or socially?		
8. Posttraumatic Stress Disorder	Have you experienced, witnessed, or had to deal with an extremely traumatic event that included actual or threatened death or serious injury to you or someone else?		
	Are you having anxiety symptoms related to a past traumatic event?		
	Are you having recurrent recollections of the events; for example, memories, flashbacks, or dreams?		
	Are you re-experiencing the event in a distressing way (such as nightmares, intense recollections, or physical reactions and reminders of trauma)?		
	Do you avoid stimuli associated with the trauma (e.g., memories, places)?		
	Do you feel emotionally numb, feel emotionally detached from your loved ones, or have you lost interest in activities you used to enjoy?		
	Have you been jumpy or agitated?		
	Does this interfere with your life?		
9. Adjustment Disorder	Have you experienced a stressful event recently?		
	Are you having trouble coping with the stressful situation?		
	Did the distress symptoms begin within 3 months of the stressful event?		
	Have you been affected or unable to do the things you normally do in your professional, home, or social life due to your current emotional state?		
10. Substance Use Disorder	In the past 12 months, have you had 3 or more alcoholic drinks within a 3-hour period on 3 or more occasions?		
	In the past 12 months, have you taken non-prescribed medication or street drugs?		
11. Bipolar Disorder	In the past month, have you		
	– felt high or had a "big" mood or irritability?		
	– been more confident?		
	– had more energy or sex drive?		
	– needed less sleep?		
12. Psychosis	Have you ever heard voices that no one else can hear?		
	Have you ever seen things or people that no one else can see, or they say that nothing is there?		
	Do you feel that people are watching or trying to harm you?		

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For each section in which you answered "Yes" to any of the questions, indicate for how many years you have been bothered by these symptoms in the table that follows.

SECTION	NUMBER OF YEARS	APPROXIMATE YEAR SYMPTOMS STARTED	HOW PROBLEMATIC IS THIS FOR YOU? INSERT ✔ IF SYMPTOMS INTERFERE WITH YOUR DAY-TO-DAY FUNCTIONS AT		
			HOME	WORK	SOCIAL LIFE
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					