Instructions for the

ADULT COMPREHENSIVE HISTORY AND QUESTIONNAIRE FORMS

The FREE Mental Health Screening Forms contain the Adult Comprehensive History and the Adult Questionnaire. The information collected in these documents can greatly aid your health care professional to give you a comprehensive mental health assessment.

While this process may seem like a lot of work, your participation gives us the information necessary to provide you with the best diagnostic assessment possible.

The process will require an hour or more of your time. Please be as accurate and complete as possible. If you need more space, you can use the back of the assessment forms.

Some of the questions will seem quite personal; but it is important that they be answered completely. Your health care professionals may wish to share this information with others involved in your care to allow us to share it with other health care professionals who are treating you. You need to know that they may not release any information about you without your written permission.

No one has a perfect memory; but do the best you can in answering the questions accurately. **It is especially important to have approximate dates for any previous treatment**. For any psychiatric medication that has been taken, start and stop dates as well as dosages are needed. Month and year will do in most cases.

Try your best; most clinicians don't expect perfection, but remember that the information you give your clinician determines your treatment. You are the most important member of your health care team.

You will notice that the instructions on the questionnaire ask **if you have ever had any of the symptoms listed.** Psychiatric symptoms will come and go, so it is important to try to remember if you have had any of these symptoms in the past, even as a child or adolescent.

After you fill out each page, you **go back through the symptoms and circle the number that corresponds to symptoms you are presently experiencing.**

For example on Page 1, #1 "I feel discouraged a lot."

If you have ever felt discouraged in the past, you would mark the appropriate box for the degree of difficulty you have ever had: **Never, Not at all — Sometimes, Just a little — Often, Pretty much — Frequently, Very much.**

If you are feeling discouraged **at this time**, you would indicate this by **Circling the number 1.**

The same is true for each question on every page.

Example:

*Please **check the appropriate box** if you have **ever experienced** any of the following symptoms.* *Please **circle the number** by any symptoms you **have now**.*	Never Not at All	Sometimes Just a Little	Often Pretty Much	Frequently Very Much
(1) I feel discouraged a lot.			X	
(2) I feel down, low, or sad most of the time.				X
3. I cry easily.		X		
(4) I get mad easily ☑ feel cranky.☐			X	
(5) I feel people are irritating me.☑ I often feel frustrated.☐			X	
(6) I blow up over little things.			X	
7. I have lost interest in activities. (sports, going out, shopping)		X		
8. I spend less time with family.	X			
9. I spend less time with friends.	X			
10. I get into fights with friends.	X			
11. I often don't feel like eating.		X		
12. I have lost weight. (_____ pounds)	X			
(13) I skip meals.				X

In this way, the health care professional gets a clearer picture of what you have experienced and what you are experiencing at this time in your life. Then the appropriate diagnosis can be made and the best treatment plan can be developed to fit your needs.

Mental health symptoms come and go. What you have experienced in the past may be as important to making the correct diagnosis as what you are experiencing now. You will notice that some questions are repeated several times. This is purposeful.

This information is essential for establishing a good understanding of your problems and for developing a treatment plan to fit your needs.

Name _____ Date _____

Address _____ City _____ State ____ Zip_____

Phone Numbers: Home _____ Cell _____ Work _____ SS# _____

Date of Birth _____ Age ___ Male ___ Female ___ Birthplace _____ Raised _____

Marital Status: Married ___ Single ___ Divorced ___ Widowed___ Separated ____ Past Marriages: Number____

Occupation _____ Current Employment _____ How long? ___

Past Jobs or Line of Work (Last 5 years) _____

_____

Family

Spouse / Significant Other Age ___ Occupation _____ Current Employment _____ How long? ___

Children Age/ City /State **Examples**: 22 / Boise, ID 8 / Dallas, Texas

Male _____

Female _____

Recent Moves (Last 5 years) _____

Mother Occupation _____ City/State _____ Age ___ Age at Death _____

Father Occupation _____ City/State _____ Age ___ Age at Death _____

Brothers Age/City/State _____

Sisters Age/City/State _____

Education

Grades K – 6	Average Grades (A – F) _____	Good Friendships: 1 2 3 4 More _____
	Behavioral Problems? _____	Academic Problems? _____
Grades 7 – 9	Average Grades (A – F) _____	Good Friendships: 1 2 3 4 More _____
	Behavioral Problems? _____	Academic Problems?_____
Grades 9 – 12	Average Grades (A – F) _____	Good Friendships: 1 2 3 4 More _____
	Behavioral Problems? _____	Academic Problems?_____

College Years 1 2 3 4 Graduated Degree _____ Major _____ Advanced Degrees ___

Trade/Technical School _____ Area(s) of Training _____

Military Service Branch _____ Years _____ Highest Rank _____ Honorable Discharge Yes No

Financial Status

Residence: Rent ___ Own Home ___ Subsidized Housing ___ Income: Low ___ Medium ____ High _____

Debt: Low ____ Medium _____ High _____ Credit: Poor ___ Fair ___Good _____ Bankruptcy ____

Healthcare: Company Health Benefits ___ Private Insurance ____ Medicaid ____ Medicare _____ Self-Pay _____

Other Income: Alimony __ Child Support __ Aid to Dependant Children __ SSI __ Retired __ Support from Relatives__

Relationships

Spouse: Poor ___ Average ____ Good _____ Parents: Poor _____ Average ____ Good _____

Brothers: Poor ___ Average ____ Good _____ Sisters: Poor _____ Average ____ Good _____

Children: Poor ___ Average ____ Good _____ Ex-Spouse: Poor _____ Average ____ Good _____

Close Friends: I can call on if in trouble: Number _____ Visit times: Weekly ___ Monthly _____ Yearly _____

Acquaintances: Number _____ Visit times: Weekly _____ Monthly ___ Yearly _____

Activities

Interests (fishing, sewing, reading, etc.) Activity _____ Times per week _____ Per Month ____

Activities with Friends Activity _____ Times per week _____ Per Month ____

Activities at Work Activity _____ Times per week _____ Per Month ____

Church Affiliation _____ Number of Times I Attend: Weekly _____ Monthly ____ Yearly ____

Environmental Stressors

Have there been any major changes in your life or your family? Please describe.

Death of friend or family member _____

Divorce _____

Moves _____

Significant Medical Problems _____

Ill Health of Family Member _____

Financial Problems _____

Abuse in Family _____

Addiction in Family _____

Violence in Family _____

Other Stressors _____

Past Psychiatric History and/or Past Mental Health Counseling

Please include: Doctor/Counselor names, Diagnosis, Dates of treatment/counseling, any Medications with dosages

_____

_____

_____

_____

_____

_____

Health Information Questionnaire

	Yes	No		Yes	No		Yes	No
Abdominal pain, chronic			Gallstones			Menstrual cramps		
Abnormal female bleeding			Gambling problems (ever)			Nail problems		
Acne			Glaucoma			Nervousness		
ADD/ADHD (ever)			Gout			Nightmares, chronic		
AIDS/HIV			Gum problems			Osteoarthritis		
Alcohol problem (ever)			Hay fever			Ovarian cancer		
Allergy to medication (ever)			Headaches, chronic			Overweight (ever)		
Allergies			Head injuries			Panic problems (ever)		
Alzheimer's disease			Hearing problems			Phobias (ever)		
Anemia			Heart attack (ever)			Physical abuse (ever)		
Anger problems (ever)			Heart beat, abnormal (ever)			PMS/Premenstrual		
Angina			Heart disease			Prostate cancer(ever)		
Anxiety problems (ever)			Heart failure			Psoriasis		
Arthritis			Heart pains			Rashes		
Asthma			Heart rhythm problems			Rectal problems		
Athletic injuries, chronic			Heartburn			Rheumatoid arthritis		
Autoimmune disease			Hepatitis			Schizophrenia (ever)		
Back pain, chronic			Herpes infection			Sexual abuse (ever)		
Baldness			High blood pressure			Sexual problems		
Bipolar disorder (ever)			High blood sugar			Sexual infection/STD		
Birth control, taking			High cholesterol			Shingles		
Bladder cancer (ever)			High triglycerides			Sickle cell anemia		
Bladder infections			Hives			Seizures (ever)		
Bleeding, abnormal			Hodgkin's disease (ever)			Severe injuries		
Blood cancer (ever)			Hyperactivity (ever)			Sinus problems		
Bowel disease			Impotence			Skin cancer (ever)		
Brain cancer (ever)			Impulsive behavior (ever)			Skin disease		
Breast cancer (ever)			Insomnia (ever)			Sleep problems		
Breathing problems			Infections, chronic			Snoring		
Broken bones			Infertility problems			Stomach cancer		
Bronchitis, chronic			Irregular periods			Stomach problems		
Cancer (ever)			Irritable bowel problems			Smoking problems		
Cataracts			Jaundice			Stress, abnormal		
Crohn's disease			Joint pain, chronic			Stroke (ever)		
Colon cancer (ever)			Kidney cancer (ever)			Sweating, abnormal		
Constipation, chronic			Kidney failure			Teeth problems		
Depression, severe (ever)			Kidney problems			Tendonitis		
Diabetes Type I ☐ Type II ☐			Leg pain			Thin bones		
Diarrhea, chronic			Liver disease			Thyroid disease (ever)		
Domestic violence (ever)			Liver, Cirrhosis			Tiredness, chronic		
Drug problems			Lung cancer (ever)			TMJ		
Ear infections, chronic			Lung problems, chronic			Tuberculosis		
Ear problems, chronic			Lymphoma			Ulcer problems		
Eating disorder (ever)			Manic depression (ever)			Urinary infections		
Emphysema			Melanoma (ever)			Urinary incontinence		
Endometriosis			Menopause problems			Urinary problems		
Eye problems			Muscle pain☐cramps☐			Uterine cancer (ever)		
Fears, abnormal (ever)			Mental health problems			Uterine fibroids		
Female pain, chronic			Migraine headaches			Vaginal infections		
Fungal infections			Mood problems (ever)			Weight problems		
Gallbladder problems			Multiple sclerosis			Yeast infections		

Medical History

If you checked any of the "Yes" boxes on the Health Information Questionnaire, please explain below.

Use separate sheet if necessary. _____

_____

_____

_____

_____

_____

_____

Hospitalization (Medical and Psychiatric with Dates and Reason for Hospitalization) _____

_____

_____

_____

_____

_____

Please list below all medications you are presently taking and the condition for which they are prescribed.

Condition	Medication	Dosage	Times per Day	Prescribing Doctor

Please list your present physician(s) and the condition(s) for which you are being treated.

Physician	Phone Number	Condition	Length of Treatment

Family History

Have any of your biological relatives (mother, father, sisters, brothers, children, aunts, uncles, grandparents) suffered from any of the following conditions? Please specify which family member and whether it is a paternal (father's side) or maternal (mother's side) relative. (For example, maternal grandmother, paternal uncle.)

Depression _____ Alcohol Problems _____

Hyperactivity (ADD) _____ Drug Problems _____

Bed Wetting _____ Schizophrenia _____

Bipolar Disorder (Manic Depression) _____ Seizures _____

Attempted Suicide _____ Completed Suicide _____

Physical Abuse _____ Sexual Abuse _____

Problems with the Law _____ Panic Attacks _____

Learning Disability _____ Anxiety _____

Tic Disorder _____ Obsessive Compulsive Behavior _____

Thyroid Disorder _____ Diabetes _____

Heart Disease _____ Cancer _____

Overweight _____ High Blood Pressure _____

Mood Swings _____ Anger Problems _____

Legal History

Arrests: Number _____ Charges _____

Convictions: Number _____ Charges _____

Driving Under the Influence: Charged Number of Times _____ Convicted Number of Times _____

Probation: Present _____ Past _____ Probation Officer _____

What Offenses? _____

Suspended Driver's License: Present _____ Past Number of Times _____

Are you a party to any lawsuits? _____ Is this causing stress for you? _____

Are you presently involved in: Divorce Proceeding Yes ___ No ___ Child Custody Dispute? Yes _____ No _____

Have you ever been involved in a bankruptcy proceeding? Yes _____ No _____ If yes, when? _____

Please explain any positive answers. _____

ADULT QUESTIONNAIRE

Name _____ Date _____

Please check the appropriate box if you have ever experienced any of the following symptoms. Please circle the question number of symptoms you have now.	Never Not at All	Sometimes Just a Little	Often Pretty Much	Frequently Very Much
1. I feel discouraged a lot.				
2. I feel down, low, or sad most of the time.				
3. I cry easily.				
4. I get mad easily ☐ feel cranky.☐				
5. I feel people are irritating me.☐ I often feel frustrated.☐				
6. I blow up over little things.				
7. I have lost interest in activities. (sports, going out, shopping)				
8. I spend less time with family.				
9. I spend less time with friends.				
10. I get into fights with friends.				
11. I often don't feel like eating.				
12. I have lost weight. (_____ pounds)				
13. I skip meals.				
14. I have gained weight recently. (_____ pounds)				
15. I eat or crave foods (sweets) when I feel sad				
16. I have a hard time going to sleep. How long? _____hours				
17. I like to stay up late regularly.				
18. I wake up in the middle of the night ☐ early in the morning.☐				
19. I like to sleep a lot ☐ take naps during the day.☐				
20. I feel bored or blah a lot.				
21. I feel restless ☐ can't sit still.☐				
22. I feel tired.				
23. I don't have much energy.				
24. I don't like myself. (feel ugly or fat)				
25. I feel worthless.				
26. I feel bad or guilty about things I have done or said.				
27. I feel like there is not much future or I feel hopeless.				
28. I have problems daydreaming.				
29. I have problems paying attention ☐ concentrating.☐				
30. I have a hard time making decisions.				
31. I don't care about life.				
32. I think about people dying.				
33. I think about suicide.				
34. I think about ways to commit suicide.				
35. I have attempted suicide.				
36. My work performance has dropped at one point.				
37. I have frequent headaches ☐ stomachaches ☐ other pains.☐				
38. I hear my name called when no one is around				
39. I hear voices that seem to come from nowhere.				
40. My mood changes quickly.☐ I have mood swings.☐				
41. I had problems learning at school. ☐ skipped school ☐				
42. I have used alcohol or drugs to feel better.				
43. I have been depressed after my child was born.				
44. As an adolescent, I ran away from home. ☐ stole ☐ lied ☐				
45. I have hit someone ☐ threatened to hit someone.☐				
46. I have had post partum depression.				
47. I have more mood problems in the winter				
48. I get depressed in the Fall ☐ Feel better in the Spring ☐				

EDM 1-48

Did you remember to circle your current symptoms?

Please check the appropriate box if you have ever experienced any of the following symptoms. Please circle the question number of symptoms you have now.	Never Not at All	Sometimes Just a Little	Often Pretty Much	Frequently Very Much
1. I feel I came close to dying. (a severe accident/abuse)				
2. I felt severely threatened or fearful at one time.				
3. I was severely injured or thought I would be.				
4. I saw someone be severely injured or hurt.				
5. I have been abused physically.				
6. I have been abused psychologically/emotionally.				
7. I have been abused sexually.				
8. I have experienced upsetting memories of events. (abuse, accident, etc.)				
9. I feel upset thinking about things that happened. (abuse, accident, etc.)				
10. I have dreams of things that have happened. (abuse, accident, etc.)				
11. I experience flashbacks of things that have happened. (abuse, accident, etc.)				
12. At times, I feel like I'm reliving what happened. (abuse, accident, etc.)				
13. I feel bad when reminded of an event. (abuse, accident, etc.)				
14. I feel upset when experiencing something similar.				
15. I try to avoid thinking of the event. (abuse, accident, etc.)				
16. I avoid things that remind me of the event. (abuse, accident, etc.)				
17. I can't remember parts of the event. (abuse, accident, etc.)				
18. I have problems with my memory.				
19. I have lost interest in normal activities. (sports, friends)				
20. I can't enjoy participating in activities.				
21. I feel different from others.				
22. I feel numb inside.				
23. I try to avoid feelings.				
24. I feel alone.				
25. I feel helpless.				
26. I feel there is no future.				
27. I have a hard time falling asleep.				
28. I wake up in the middle of the night.				
29. I get angry easily.				
30. I feel irritable.				
31. I daydream at work.				
32. I have problems concentrating.				
33. I seem on edge all the time.				
34. I startle very easily.				
35. I sweat at times for no reason.				
36. I sweat when reminded of the event. (abuse, accident, etc.)				
37. I fight with my spouse ☐ my children.☐				
38. I feel people are trying to control me.				
39. I have problems with my brothers ☐ my sisters.☐				
40. I have problems with friends.				
41. I feel like it's happening all over again. (abuse, accident, etc.)				
42. I feel certain my negative thoughts will come true.				
43. I feel I will be hurt if I talk about my abuse.				
44. I feel if I let go, my feelings will be out of control.				

DSTP 1-44

Did you remember to circle your current symptoms?

Please check the appropriate box if you have ever experienced any of the following symptoms. Please circle the question number of symptoms you have now.	Never Not at All	Sometimes Just a Little	Often Pretty Much	Frequently Very Much
1. I often make careless mistakes ☐ have difficulty with details.☐				
2. I often have difficulty sustaining attention ☐ focusing. ☐				
3. I often have had a hard time listening.				
4. I often have had a hard time with instructions.				
5. I often have had a hard time organizing things.				
6. I often haven't liked activities that require a lot of mental effort.				
7. I often loose things. (keys, notes, etc.)				
8. I have often been easily distracted by activities around me.				
9. I have forgotten things quite often.				
10. People often say I'm fidgety ☐ that I was fidgety when younger.☐				
11. I have difficulty staying seated. As a child ☐ As an adult ☐				
12. I often feel restless inside. ☐ I ran and climbed as a child. ☐				
13. People say I talk too loudly. ☐ I talked out in class at school. ☐				
14. I have to be on the go.☐ I feel driven.☐				
15. People would say I talk too much.				
16. I often answer questions before they are completed.				
17. I often have had difficulty waiting my turn in traffic ☐ lines.☐				
18. I often interrupt others. As a child ☐ As an adult ☐				
19. As a child in school, I avoided doing homework.				
20. As a child in school, I would forget my homework.				
21. As a child in school, I had a difficult time finishing schoolwork or chores.				
22. As a child in school, I had to move my hands and feet all the time.				
23. As a child in school, I had to get up and move around the room.				
24. I pay attention to unimportant things.				
25. I needed to be in the front of the line when I was younger.				
26. I talked out in class when I was younger.				
27. As a child, I had to be told several times to do things.				
28. As a child, my parents complained about my not paying attention.				
29. I can't complete tasks.				
30. People have said I'm loud or excitable.				
31. I can't keep my mouth shut.				
32. I butt into conversations.				
33. I space things off.				
34. I can't get my work completed.				
35. I like to take risks.☐ I am or was a daredevil.☐				
36. I would run away from my parents when I was younger.				
37. I don't think about the consequences of my actions.				
38. I do dumb things and don't know why.				
39. I am or have been hyper.				
40. I am or have been impulsive.				

DHDA 1-40

Did you remember to circle your current symptoms?

Please check the appropriate box if you have ever experienced any of the following symptoms. Please circle the question number of symptoms you have now.	Never Not at All	Sometimes Just a Little	Often Pretty Much	Frequently Very Much
1. I used drugs or alcohol as an adolescent.				
2. I missed school because of use as an adolescent.				
3. I have had problems at work because of use.				
4. I have had problems with my family because of use.				
5. I have had problems with the law because of use.				
6. I have had a DUI charge. ☐ I have had my license suspended. ☐				
7. These problems did not cause me to stop using.				
8. I have had money problems because of use.				
9. I have borrowed money from friends to buy drugs or alcohol.				
10. I have blacked out while using.				
11. I have had shakes in the morning after using.				
12. I have drunk more or used more than I wanted to.				
13. I have gotten drunk or high when I did not expect to.				
14. I have unsuccessfully tried to cut back on using.				
15. I have had to use more to get the same effect.				
16. I have had an accident while using.				
17. I have driven while drinking. ☐ while using drugs ☐				
18. I can drink more than most people.				
19. I use regularly.				
20. I quit using and started again.				
21. I have been in treatment for use. ☐ involved in AA or NA ☐				
22. I have had medical problems because of use.				
23. Most of my friends use.				
24. I use to deal with my feelings.				
25. I get into fights when I'm using. ☐ argue when I'm using ☐				
26. I rarely have hangovers after drinking.				
27. I have gone without things to buy drugs or alcohol.				
28. I have skipped meals when I was using.				
29. I have used until everything was gone.				
30. I have sexually acted out when using.				
31. I have a hard time getting up in the morning after using.				
32. I have neglected my children due to use.				
33. I have dealt drugs.				
34. I need to use to have fun.				

AD 1-34

Did you remember to circle your current symptoms?

EXAMPLE OF HOW TO FILL OUT THIS PAGE

Substances Examples	How much I use	How often I use	How long I have used	How old I was when I started	When I last used
Alcohol	1 case a day	Daily	14 years	12	Last night
Marijuana	10 bowls a day	Every weekend	16 years	10	2 weeks ago

Your Drug and Alcohol Use

Substance	How much I use	How often I use	How long I have used	How old I was when I started	When I last used
Cigarettes/Chew					
Caffeine					
Alcohol					
Marijuana (Pot)					
LSD (Acid, Fry)					
PCP (Angel Dust) Ketamine “Special K”					
Cocaine (Coke)					
Crack					
Speed (Crank)					
Crystal Meth					
Heroin					
Gasoline					
Visine eye drops (to hide use of marijuana)					
Abuse of cough syrup, over-the counter drugs					
Mescaline (“Shrooms”)					
Ecstasy					
OxyContin/Narcotic pain medications, Morphine					
Glue, Paint thinner, Spray paint, “Huffing”					
Dramamine					
Abused prescribed medications					
Other Substances Abused _____					

Please check the appropriate box if you have ever experienced any of the following symptoms. Please circle the question number of symptoms you have now.	Never Not at All	Sometimes Just a Little	Often Pretty Much	Frequently Very Much
1. I bully or threaten others.				
2. I have stolen from someone. (mugging)				
3. As an adolescent, I ran away overnight.				
4. As an adolescent, I stayed out all night against my parents' wishes.				
5. As an adolescent, I lied to my parents regularly to get out of trouble.				
6. As a child or adolescent, I set fires.				
7. As an adolescent, I skipped school more than once.				
8. As an adolescent, I broke into a house ☐ car.☐				
9. As an adolescent, I destroyed property.				
10. As a child or adolescent, I hurt animals.				
11. I have forced someone to have sex.				
12. I used a weapon in a fight.				
13. As an adolescent, I started fights.				
14. As an adolescent, I stole from stores ☐ cars ☐ neighbors.☐				
15. I have been arrested.				
16. I am cruel to people and don't feel bad about it.				
17. I lose my temper often.				
18. I often argue with people.				
19. I often defy rules.				
20. I often refuse to do what I am asked.				
21. I often do things deliberately to annoy people.				
22. I often blame other people for my mistakes.				
23. I often feel annoyed by others.				
24. I often feel touchy.				
25. I often feel angry.				
26. I often feel resentful.				
27. I often feel like getting back at people.				
28. I have tried to kill myself but did not really want to die.				
29. At times I feel I can do almost anything.☐ I have big plans.☐				
30. When I feel high or irritated, I am easily distracted.				
31. I get irritated ☐ angry ☐ for little or no reason.				
32. My thoughts go very fast at times.				
33. There are times I get by on little sleep. (4 - 5 hours)				
34. I sleep a lot at times. (12 hours or more)				
35. At times I need to talk a lot ☐ interrupt conversations.☐				
36. Sometimes people say I talk fast.				
37. When I feel angry or good, I drive fast. ☐ spend too much. ☐				
38. When I feel good or angry, I party too much. ☐ clean too much. ☐				
39. I am easily frustrated when I am high ☐ irritable.☐				
40. When younger, I threw severe temper tantrums at times.				
41. I do risky things without thinking ☐ act impulsively.☐				
42. I feel very good at times, ☐ on top of the world.☐				
43. Sometimes I feel super sexy ☐ very interested in sexual activities.☐				
44. I become aggressive easily ☐ have rage attacks.☐				
45. I get hyper at times. ☐ I have many projects when I feel hyper.☐				
46. I have big or drastic mood swings.				

DC 1-16 DDO 17-27 DB 28-46 *28-46

Did you remember to circle your current symptoms?

Please check the appropriate box if you have ever experienced any of the following symptoms. Please circle the question number of symptoms you have now.	Never Not at All	Sometimes Just a Little	Often Pretty Much	Frequently Very Much
1. My worst fear is looking stupid or being embarrassed.				
2. I do not do things or talk to people for fear of embarrassment.				
3. I avoid activities in which I am the center of attention.				
4. I feel short of breath or like I am smothering.				
5. I feel dizzy ☐ lightheaded ☐ unsteady ☐ faint.☐				
6. I feel my heart pound or beat rapidly.				
7. I tremble or shake. ☐ I sweat for no reason. ☐				
8. I get super anxious quickly. (5 – 15 minutes)				
9. I feel panicky at times.				
10. I feel unreal or detached from myself.				
11. I feel numb or tingly. ☐ I feel like I'm choking. ☐				
12. I have unexplained chills ☐ hot flashes ☐				
13. I have chest pains ☐ discomfort in my chest ☐				
14. I fear that I might die ☐ go crazy.☐				
15. I fear being out of control.				
16. When anxious, I have an upset stomach ☐ nausea ☐ diarrhea.☐				
17. I am afraid of snakes ☐ dogs ☐ spiders ☐ heights ☐ other ☐_____				
18. I fear social situations.				
19. I fear going to work.				
20. I fear going outside.				
21. I feel anxious or worried a lot.				
22. I cannot control my worries.				
23. I feel restless, keyed up, or on edge.				
24. I have I have difficulty paying attention ☐ my mind goes blank.☐				
25. I have a lot of muscle ache ☐ muscle tension.☐				
26. I feel tired a lot.				
27. I have a hard time sleeping.				
28. I sweat for no reason.				
29. I feel really irritable.				
30. My hands get cold and clammy.				
31. My mouth gets dry a lot.				
32. I feel light headed.				
33. I startle easily.				
34. I feel like I have a lump in my throat.				
35. I feel like I'm on the edge.				
36. I have to urinate frequently.				
37. I have disturbing thoughts ☐ impulses ☐ images.☐				
38. I try to push down disturbing thoughts ☐ impulses ☐ images.☐				
39. I have thoughts ☐ impulses ☐ images.☐ that seem senseless.				
40. The thoughts ☐ impulses ☐ images ☐ are in my head.				
41. I have a hard time ignoring disturbing thoughts ☐ impulses ☐ images.☐				
42. I feel that I have obsessions ☐ thoughts I can't stop.☐				
43. I do things because of thoughts I can't stop. (washing ☐ checking ☐)				
44. I do things to prevent feeling bad. (washing ☐ checking ☐ counting.☐)				
45. I can't stop doing some things. (washing ☐ counting ☐ checking.☐)				
46. Obsessions or thoughts cause me to feel bad.				
47. Obsessions or thoughts keep me from doing things.				
48. I do things to prevent thoughts. (checking ☐ washing ☐ counting ☐)				
49. I frequently wash my hands ☐ check things ☐ put things in order.☐				
50. I frequently pray ☐ count ☐ repeat words.☐				

Did you remember to circle your current symptoms? DAS 1-3 DP 4-16 PS 17-20 DAG 21-36 DCO 37-50

Please check the appropriate box if you have ever experienced any of the following symptoms. Please circle the question number of symptoms you have now.	Never Not at All	Sometimes Just a Little	Often Pretty Much	Frequently Very Much
1. I often feel abandoned.				
2. I get very upset when people leave me.				
3. I am unable to be alone.				
4. I am often disappointed by relationships.				
5. I often idealize people.				
6. I need to be close to people too quickly.				
7. I feel I give too much.				
8. I feel people don't give back.				
9. I feel people punish me for no reason.				
10. I often feel bad or evil.				
11. My feelings about myself change quickly.				
12. I feel safer in a structured environment.				
13. I often gamble too much.				
14. I often spend more than I should.				
15. I engage in unsafe sex at times.				
16. I often abuse substances (alcohol or drugs).				
17. I often drive recklessly.				
18. I often threaten suicide.				
19. I have attempted suicide.				
20. I have frequently attempted suicide.				
21. I cut on myself when I'm upset.				
22. I pull out my hair when I'm upset.				
23. I hit myself when I'm upset.				
24. I pick at myself when I am nervous.				
25. I bang my head when I'm upset.				
26. I often burn myself.				
27. I have extreme mood swings.				
28. I am basically unhappy most of the time.				
29. I rarely feel satisfied or feel good.				
30. I have frequent periods of unexplained despair.				
31. I have frequent periods of unexplained panic.				
32. I have frequent periods of unexplained anger.				
33. I feel empty most of the time.				
34. I feel bored a lot.				
35. I have a hard time controlling my anger.				
36. I am often sarcastic.				
37. At times I feel paranoid when stressed.				
38. My doctor tells me I do not weigh enough.				
39. I always think I'm too fat.				
40. I'm afraid of gaining any weight.				
41. Since I lost weight, my periods have stopped.				
42. Parts of my body are always too big.				
43. I lose weight but still feel fat.				
44. When I eat too much, I throw up.				
45. If I feel too heavy, I exercise a lot.				
46. I use diuretics or laxatives to lose weight.				
47. I like to fast or diet a lot.				
48. I often binge eat.				

DPB 1-37 NA 38-48

Did you remember to circle your current symptoms?

Please check the appropriate box if you have ever experienced any of the following symptoms. Please circle the question number of symptoms you have now.	Never Not at All	Sometimes Just a Little	Often Pretty Much	Frequently Very Much
1. I often feel people are out to get me.				
2. I think people are watching me.				
3. People want to persecute me.				
4. Songs or books are written about me.				
5. Sometimes shows on TV are about me.				
6. People are trying to steal my thoughts.				
7. I feel that I have been taken over by aliens.				
8. I hear my name called when there is no one around.				
9. At times, I hear voices that threaten me.				
10. At times, a voice will call me names.				
11. At times, I hear conversations in my head.				
12. Sometimes I see things that are not there.				
13. My thoughts often change rapidly.				
14. People tell me I don't make sense.				
15. I have a hard time sticking to a topic.				
16. My thoughts are often disorganized.				
17. I often get off track.				
18. Sometimes I do weird things.				
19. People say I dress funny.				
20. Sometimes I yell and scream for no reason.				
21. Sometimes I do sexual things in public.				
22. Sometimes it feels like I can't move for long periods.				
23. I get so excited other people get scared.				
24. I look flat most of the time.				
25. It's hard to look people in the eye.				
26. People say I am not very expressive.				
27. Most of the time, I don't have much to say.				
28. My answers to questions are usually short.				
29. It is hard to maintain a thought when I talk.				
30. I just don't care about anything.				
31. I have severe problems at work.				
32. It seems I can't get along with anyone.				
33. It's hard to keep clean.				
34. People say I am very capable.				
35. People say, "If you would only apply yourself."				
36. At times, I eat a lot at once.				
37. When I eat a lot, I eat very fast.				
38. I feel guilty when I eat a lot.				
39. I eat when I'm depressed.				
40. I feel out of control when I eat a lot.				
41. When I eat a lot, I throw up.				
42. It is very easy for me to vomit.				
43. Sometimes I stick my fingers down my throat.				
44. After I eat, I frequently use laxatives ☐ diuretics.☐				
45. I am very concerned about my weight.				
46. I eat a lot when I'm angry.				
47. I eat a lot when I feel lonely.				
48. When I eat a lot, for a short while, I feel less depressed.				
49. Whenever I think about what I have eaten, I am self-critical ☐ depressed.☐				

HCS 1-35 NB 36-49

Did you remember to circle your current symptoms?