

Current Problems or Symptoms

Please read each item below and determine which statement is true for you. Then, place an X in the appropriate box to indicate how often you feel the statement applies to you during the past month.

Be sure to rate every item. Example:

		None or a little of the time	Some of the time	Most or all of the time
DURING THE PAST YEAR				
1	I feel sad		X	

		None or a little of the time	Some of the time	Most or all of the time
DURING THE PAST YEAR				
A	1. Wake up at night or in the early morning and unable to return to sleep.			
	2. Very restless sleep			
	3. Loss of energy			
	4. Decreases sex drive			
	5. Unable to enjoy life, lost a feel for life.			
	6. Have withdrawn from others			
	7. Strong thoughts about suicide			
	8. Loss of appetite			
	9. Memory problem, forgetfulness, poor concentration			
	10. Weight Loss (How much in the past month? ___ lbs.) (In the past year? _____ lbs.)			
B	Weight Gain (How much in the past month? ___ lbs.) (In the past year? _____ lbs.)			
	11. Decreased need for sleep			
	12. Increased sex drive			
	13. Increased energy			
C	14. So happy that people describe me as manic			
	15. Can't get to sleep			
	16. Sudden episodes of nervousness or panic			
	17. Fear or loss of self control			
D	18. Palpitations or rapid heart beat			
	19. Shortness of breath			
	20. Strange or unusual thoughts			
E	21. Hallucinations, hear voices, or see things that are not there.			
	22. Very peculiar experiences			
	23. Ready to explode			
	24. Thoughts about harming someone			
	25. Excessive use of alcohol/ drugs			