Name: _____ Date: _____

Diagnostic Screening Tool

Section I: Mood

During the past **MONTH**, how much have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day
1. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4
2. Feeling so good, excited, or hyper that other people thought you were not your normal self or you got into trouble?	0	1	2	3	4
3. Sleeping less than usual, but still had a lot of energy?	0	1	2	3	4
4. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4

At any time in your life, how much have you ever been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day
5. Little interest or pleasure in doing things	0	1	2	3	4
6. Feeling down, depressed, or hopeless	0	1	2	3	4
7. Feeling more irritated, grouchy, or angry than usual	0	1	2	3	4
8. Sleeping less than usual, but still have a lot of energy	0	1	2	3	4
9. Starting lots more projects than usual or doing more risky things than usual	0	1	2	3	4
10. Thoughts of actually hurting yourself	0	1	2	3	4

Section II: Sleep

During the past **MONTH**, how much (or how often) have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day
11. Persistent difficulty falling asleep or staying asleep?	0	1	2	3	4

12. Daytime problems related to trouble sleeping, such as fatigue, increased irritability, or trouble concentrating?	0	1	2	3	4
13. Worry or distress about your sleep?	0	1	2	3	4

How many hours of sleep do you get in an average night? _____

Section III: Anxiety

During the past **MONTH**, how much (or how often) have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day
14. Having a panic attack that came out of the blue (a sudden, unpredicted onset of intense fear or discomfort accompanied by intense bodily sensations and an intense urge to flee that reached its peak intensity within several minutes)?	0	1	2	3	4
15. Persistent concern about having a panic attack, worry about the implications or consequences of the attack, or a significant change in behavior related to the attacks?	0	1	2	3	4
16. Avoiding or feeling afraid of being in places or situations in which you may experience panic symptoms (e.g., being in crowds, standing in line, being in open spaces, or traveling on buses or trains or airplanes)?	0	1	2	3	4
17. Avoiding or feeling very fearful in social or performance situations (e.g., public speaking, parties, dating) because you think you will humiliate or embarrass yourself or be judged negatively by others?	0	1	2	3	4
18. Avoiding or feeling very fearful in relation to other things or situations such as flying, seeing blood, getting an injection, heights, small enclosed places, or certain kinds of animals or insects? If so, what do you fear/avoid:	0	1	2	3	4

_____					
19. Worrying excessively, more days than not, about a several events/activities and finding it difficult to control the worry?	0	1	2	3	4
20. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4
21. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4

Have any of the following events ever happened to you?	**Yes**	**No**	**If Yes, at what age?**
Experiencing or witnessing an event that involved actual or threatened death or serious injury to yourself or another person			
You were sexually abused, meaning touched or having to touch someone in a sexual way against your will			
Sexual assault or rape			

If you checked any of the above, has that experience led to any of the following? (please check if so)

_____ Repeated involuntary memories, dreams, or flashbacks of the traumatic event

_____ Avoiding people, places, activities, objects, or situations that remind you of what happened

Section III: Substance Use

Please specify quantity/frequency (e.g., 2 glasses of wine per day) of most frequent and current use for each of the following:

Substance	**Most frequent use**	**Current use**
	Quantity/Frequency	**Quantity/Frequency**
Caffeine (e.g., coffee, black tea, dark chocolate)		
Tobacco (e.g., cigarettes, cigars, chewing tobacco)		
Alcohol (e.g., beer, wine, hard liquor)		

Sedatives (e.g., Valium, Xanax, Klonopin, Ambien, Sonata, Lunesta, barbiturates, Ativan, Halcion, Restoril)		
Cannabis (e.g., marijuana, hashish, THC, pot, grass, weed)		
Stimulants (e.g., amphetamine, speed, crystal meth, dexadrine, Ritalin, ice)		
Opioids (e.g., heroin, morphine, opium, Methadone, Darvon, codeine, Percodan, Demerol, Dilaudid, oxycontin, oxycodone, hydrocodone, vicodin)		
Cocaine (e.g., crack, speedball)		
Hallucinogens (e.g., LSD, mescaline, peyote, psilocybin, STP, mushrooms, Ecstasy, MDMA)		
PCP (e.g., angel dust, Special K)		
Other (e.g., steroids, nonprescription sleep or diet pills, cough syrup)		

	Yes	**No**
Have you ever felt you ought to cut down on your drinking or substance use?		
Have people annoyed you by criticizing your drinking or substance use?		
Have you ever felt bad or guilty about your drinking or substance use?		
Have you ever had a drink or used substances first thing in the morning to steady your nerves or to get rid of a hangover?		

Section IV: Additional History

At any time in your life, how much (or how often) have you ever been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day
1. Feeling preoccupied with a perceived defect in your appearance (e.g., your height, the shape of your nose, hair loss, your complexion)	0	1	2	3	4
2. Dissatisfaction with my weight	0	1	2	3	4
3. Weighing much less than other people thought you ought to weigh and worrying about becoming fat	0	1	2	3	4
4. Eating large amounts of food and feeling you cannot control how much	0	1	2	3	4

you are eating					
5. Making yourself vomit, use laxatives, or exercise a lot to prevent weight gain	0	1	2	3	4
6. Persistent difficulties with paying attention, being easily distracted, losing things, or organizing tasks or activities	0	1	2	3	4
7. Feeling restless when you're sitting still, interrupting others, blurting out things you wish you could take back, difficulty doing leisure activities quietly, or acting without thinking	0	1	2	3	4
8. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)	0	1	2	3	4
9. Feeling that your illnesses are not being taken seriously enough	0	1	2	3	4
10. Hearing things other people couldn't hear, such as voices even when no one was around	0	1	2	3	4
11. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking	0	1	2	3	4
12. Recurrently pulling out your hair or picking at your skin to the degree that you experience noticeable hair loss or bleeding or disfigurement from skin picking	0	1	2	3	4
13. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)	0	1	2	3	4
14. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories	0	1	2	3	4
15. Not knowing who you really are or what you want out of life	0	1	2	3	4
16. Not feeling close to other people or enjoying your relationships with them	0	1	2	3	4
17. Difficulties communicating your thoughts and feelings to other people	0	1	2	3	4

What psychiatric diagnoses, if any, have you ever received?

_____