Name: _____ Date:_____

What are your priorities for your visit today? _____

Check and fill regarding the past two weeks

APPETITE : ☐ normal for me. ☐ higher than usual ☐ higher than desired ☐ lower than usual ☐ lower than desired

WEIGHT: Current wt _____ Compared to last visit its… ☐ about the same ☐ increased __ lbs ☐ decreased __ lbs

ENERGY: ☐ adequate ☐ less than desired ☐ less than adequate ☐ poor ☐ more than adequate ☐ abundant

Over the last 2 weeks, how often have you been bothered by the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
Feeling nervous, **anxious** or on edge	☐	☐	☐	☐
Not being able to stop or control worrying	☐	☐	☐	☐
Worrying too much about different things	☐	☐	☐	☐
Trouble relaxing	☐	☐	☐	☐
Being so **restless** that it is hard to sit still	☐	☐	☐	☐
Becoming easily annoyed or **irritable**	☐	☐	☐	☐
Feeling afraid as if something awful might happen	☐	☐	☐	☐
Little interest or pleasure in doing things	☐	☐	☐	☐
Feeling **down**, **depressed**, or **hopeless**	☐	☐	☐	☐
Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
Feeling tired or having little energy	☐	☐	☐	☐
Poor appetite or overeating	☐	☐	☐	☐
Feeling bad about yourself — or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐
How difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all ☐	Somewhat difficult ☐	Very difficult ☐	Extremely difficult ☐

PHYSICAL ACTIVITY: How many minutes/day? __, days/week? __. types:_____

SLEEP: Average hrs/night___. ☐ unbroken ☐ broken up ☐ rested ☐ not rested ☐ CPAP used ☐ nightmares

MOTIVATION for daily *required* activities (hygiene/grooming, chores, bills, errands, meal preparation, etc.):

☐ adequate ☐ less than desired ☐ less than adequate ☐ inadequate ☐ more than usual ☐ more than adequate ☐ abundant

What is not getting done? _____

THOUGHTS: are … ☐ quiet / neutral ☐ sluggish / slowed ☐ accelerated ☐ racing

UNUSUAL PERCEPTIONS or experiences others don't have? _____

SNAP DECISIONS with real or potential negative consequences? _____

THOUGHTS OF SERIOUSLY INJURING OR KILLING ANOTHER PERSON? _____

SEXUAL DRIVE/ FUNCTION: ☐ nml interest ☐ higher ☐ lower ☐ typically high ☐ typically low ☐ difficulty achieving orgasm

☐ Having 4 or more drinks of any kind of alcohol in a single day

☐ Using any tobacco products

☐ Using any of the following ON YOUR OWN, (that is, in greater amounts or longer than prescribed or without a prescription) **painkillers** (like Vicodin), **stimulants** (like Ritalin or Adderall), **sedatives/ tranquilizers** (like sleeping pills, Klonopin, Xanax,etc.)

☐ Using other drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)