

## Behavioral Health Screening

1. **Have you been depressed recently?** Depression involves feeling down much of the time, having low energy, not caring, it's hard to keep moving. Depression is different from normal sadness due to life events

**No (skip to #2)**       **Yes (Complete items below)**

**Please check all symptoms you experience when depressed**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Can't stop crying          | <input type="checkbox"/> Poor motivation    | <input type="checkbox"/> Feel numb          |
| <input type="checkbox"/> No energy                  | <input type="checkbox"/> Poor concentration | <input type="checkbox"/> Moody, down        |
| <input type="checkbox"/> Hard to make decisions     | <input type="checkbox"/> Poor self-esteem   | <input type="checkbox"/> Hopeless           |
| <input type="checkbox"/> Loss of interest           | <input type="checkbox"/> Guilt              | <input type="checkbox"/> Can't sit still    |
| <input type="checkbox"/> Unable to feel pleasure    | <input type="checkbox"/> Sleep problems     | <input type="checkbox"/> Worry              |
| <input type="checkbox"/> Sudden Weight loss or gain | <input type="checkbox"/> No appetite        | <input type="checkbox"/> Tired all the time |
| <input type="checkbox"/> Thoughts about death       | <input type="checkbox"/> Suicidal thoughts  | <input type="checkbox"/> Suicidal plan      |

**How long have been consistently depressed? (Circle the answer that best fits you)**

1-4 weeks	1-3 months	4-6 months	6-12 months	Over a year
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**How often do you have episodes of depression?**

1	2	3	4	5	6	7	8	9	10
Once per year	Every 7-9 months	Every 4-6 months	Every 2 to 3 months	1-3 times per month	4-6 times per month	1-3 days per week	4-6 days per week	Every day	All the time

**How bad is it? – How much does it interfere with activities or relationships?**

1	2	3	4	5	6	7	8	9	10
Does not interfere		Causes minor problems sometimes		Causes moderate Problems sometimes		Causes major problems sometimes		Causes major problems regularly	Can't function

2. **Have you been stressed or had problems with impulse control or temper?**

**No (Skip to #3)**       **Yes (complete items below)**

**How long?**

1-4 weeks	1-3 months	4-6 months	6-12 months	Over a year
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**How Often?**

1	2	3	4	5	6	7	8	9	10
Once per year	Every 7-9 months	Every 4-6 months	Every 2 to 3 months	1-3 times per month	4-6 times per month	1-3 days per week	4-6 days per week	Every day	All the time

**How Bad? – How much does it interfere with normal activities or relationships?**

1	2	3	4	5	6	7	8	9	10
Does not interfere		Causes minor problems sometimes		Causes moderate Problems sometimes		Causes major problems sometimes		Causes major problems regularly	Can't function

**3. Have you been anxious or had panic attacks recently?**

No (Skip to #4)                       Yes (complete items below)

**Please check all symptoms you experience when anxious:**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Shaking                | <input type="checkbox"/> Can't breathe              | <input type="checkbox"/> Chest pains      |
| <input type="checkbox"/> Heart palpitations     | <input type="checkbox"/> Muscle tension             | <input type="checkbox"/> Nausea           |
| <input type="checkbox"/> Chills or hot flashes  | <input type="checkbox"/> Avoid places or situations | <input type="checkbox"/> Choking feeling  |
| <input type="checkbox"/> Feel out of control    | <input type="checkbox"/> Feel out of touch          | <input type="checkbox"/> Can't sit still  |
| <input type="checkbox"/> Sweat without activity | <input type="checkbox"/> Feelings of unreality      | <input type="checkbox"/> Dizziness        |
| <input type="checkbox"/> Numbness or tingling   | <input type="checkbox"/> Fear of going crazy        | <input type="checkbox"/> Feelings of doom |

**How long have you suffered from anxiety?**

1-4 weeks	1-3 months	4-6 months	6-12 months	Over a year
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**How often do you have bouts of anxiety?**

1	2	3	4	5	6	7	8	9	10
Once per year	Every 7-9 months	Every 4-6 months	Every 2 to 3 months	1-3 times per month	4-6 times per month	1-3 days per week	4-6 days per week	Every day	All the time

**How bad is it? – How much does it interfere with normal activities or relationships?**

1	2	3	4	5	6	7	8	9	10
Does not interfere		Causes minor problems sometimes		Causes moderate Problems sometimes		Causes major problems sometimes		Causes major problems regularly	Can't function

**4. Have you experienced any of the following: (Circle yes or no)**

Yes	No	Racing thoughts	Yes	No	Hallucinations	Yes	No	Delusions
Yes	No	Suicide Attempt	Yes	No	Hospitalization for Mental Health Concern			
Yes	No	Suicide Plan						

**5. How much have health problems interfered with your activities or relationships in the past month?**

1	2	3	4	5	6	7	8	9	10
Does not interfere		Causes minor problems sometimes		Causes moderate Problems sometimes		Causes major problems sometimes		Causes major problems regularly	Can't function without help

**6. Please rate your overall health:**

1	2	3	4	5	6	7	8	9	10
Excellent		Occasional minor problems		Chronic problems but do OK		Not very healthy		Health is very poor	Critical health problems