

Behavioral Health Update

1. Have you been depressed since your last appointment?

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

Please circle the letter that best describes changes in your symptoms since your last visit

N = not present; I = improved S = Same W = Worse

- | | | |
|------------------------------------|----------------------------|----------------------------|
| N I S W Can't stop crying | N I S W Poor motivation | N I S W Feel numb |
| N I S W No energy | N I S W Poor concentration | N I S W Down mood |
| N I S W Hard to make decisions | N I S W Poor self-esteem | N I S W Hopeless |
| N I S W Loss of interest | N I S W Guilt | N I S W Can't sit still |
| N I S W Unable to feel pleasure | N I S W Sleep problems | N I S W Worry |
| N I S W Sudden Weight loss or gain | N I S W No appetite | N I S W Tired all the time |
| N I S W Thoughts about death | N I S W Suicidal thoughts | N I S W Suicidal plan |

How Often?

1	2	3	4	5	6	7	8	9	10
None	Every 3-6 months	Every 5 to 8 weeks	1-2 times per month	3-4 times per month	1-3 times per week	4-6 times per week	At least every day	Most of 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

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

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

How Often?

1	2	3	4	5	6	7	8	9	10
None	Every 3-6 months	Every 5 to 8 weeks	1-2 times per month	3-4 times per month	1-3 times per week	4-6 times per week	At least every day	Most of 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?

N I S W _No (Skip to #3) Yes (complete items below)

Please circle the letter that best describes changes in your symptoms since your last visit

N = not present; I = improved S = Same W = Worse

- | | | |
|--------------------------------|------------------------------------|--------------------------|
| N I S W Shaking | N I S W Can't breathe | N I S W Chest pains |
| N I S W Heart palpitations | N I S W Muscle tension | N I S W Nausea |
| N I S W Chills or hot flashes | N I S W Avoid places or situations | N I S W Choking feeling |
| N I S W Feel out of control | N I S W Feel out of touch | N I S W Can't sit still |
| N I S W Sweat without activity | N I S W Feelings of unreality | N I S W Dizziness |
| N I S W Numbness or tingling | N I S W Fear of going crazy | N I S W Feelings of doom |

How Often?

1	2	3	4	5	6	7	8	9	10
None	Every 3-6 months	Every 5 to 8 weeks	1-2 times per month	3-4 times per month	1-3 times per week	4-6 times per week	At least every day	Most of 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

4. 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

5. 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

6. Have you experienced any new stressors or trauma since your last visit

Yes No