Diagnostic Screening Tool **Initials _____** **Date _____**

Section I: Mood

1. In the last month has there been a period of time lasting at least 2 weeks when you:	**Yes**	**No**
a. Felt depressed or down most of the day nearly every day?		
b. Felt a loss of interest or pleasure in most things you normally enjoy for most of the day nearly every day?		

If you answered "Yes" to "a" or "b," indicate which of the following symptoms you experienced during the time you experienced "a" or "b."

___ Loss of appetite nearly every day
___ Increase in appetite nearly every day
___ Weight loss not due to dieting Amount lost (lbs) _____
___ Weight gain Amount gained (lbs) _____
___ Difficulty concentrating or indecisiveness nearly every day
___ Increase in number of hours slept nearly every day
___ Decrease in number of hours slept nearly every day
___ Feeling fidgety, agitated or restless nearly every day
___ Feeling slowed down, sluggish nearly every day
___ Recurring thoughts of suicide, death, or dying
___ Making a plan for suicide
___ Taking some action toward suicide
___ Fatigue or loss of energy
___ Feelings of worthlessness or excessive guilt nearly every day

	Yes	**No**
2. Prior to last month, did you ever have at least a 2 week period when you felt depressed or experienced a loss of interest or pleasure in most things you normally enjoyed?		
a. Approximately how many times has this happened? _____ b. Approximately how old were you when this happened for the first time? ____		
3. Have you experienced depressed mood most of the day nearly every day for at least 2 years?		
a. Is that happening now or was it in the past? Now ___ In the past___		
4. In the **last month**, has there been a period of time when you were feeling so good, high, excited, "hyper," or irritable that other people thought you were not your normal self or you got into trouble?		
a. How many days did that period of time last? ____		
5. Have you **ever** had a time when you were feeling so good, high, excited, "hyper," or irritable that other people thought you were not your normal self or you were so hyper that you got into trouble?		
6. Have you ever experienced periods in which your mood cycles from periods of low depressed mood and low energy to periods of elated mood with high energy?		

Section II: Substance Use

	Past (Yes/No)	Currently (Yes/No)
1. Have you ever consumed alcohol?		
2. Have you ever used illicit drugs?		
3. Have you ever used medications (prescription or non prescription) other than as directed?		

If no to all, please skip to Section III.
If yes to any of these questions, please specify quantity/frequency (e.g., 2 glasses of wine per day):

Substance	Past		Currently	
	Quantity	Frequency	Quantity	Frequency
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, glue, ethyl chloride, paint, inhalants, nitrous oxide (laughing gas), amyl or butyl nitrate (poppers), nonprescription sleep or diet pills, cough syrup)				

	Yes	No
4. Have you ever felt you ought to cut down on your drinking or substance use?		
5. Have people annoyed you by criticizing your drinking or substance use?		
6. Have you ever felt bad or guilty about your drinking or substance use?		
7. 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?		

8. Please indicate areas where your alcohol or substance use caused problems in the last six months:

Work ____ Legal ____ School _____ Health ____ Relationships ____
Leisure activities____ Financial ____

Section III: Anxiety

	Yes	No
1. Have you ever had a panic attack (a sudden onset of intense fear or discomfort accompanied by intense bodily sensations and an intense urge to flee that reached its peak intensity within 10 minutes)?		
a. If yes, please check symptoms experienced: ___Pounding, racing heart ___Dizzy, lightheaded or faint ___Fear of losing control, going crazy ___Numbness or tingling sensations ___Chest pain or discomfort ___Shortness of breath ___Sweating ___Feelings of unreality or detached ___Nausea/abdominal distress ___Chills or hot flushes ___Fear of dying ___Feelings of choking ___Trembling, shaking		
b. Have you ever had a panic attack that seemed to happen out of the blue (e.g., for no apparent reason)?		
c. Has the panic attack been followed by persistent concern about having additional attacks, worry about the implications or consequences of the attack, or a significant change in behavior related to the attacks?		
2. Do you avoid or feel afraid of being in places or situations in which you may experience panic symptoms (e.g., being in crowds, standing in line, or traveling on buses or trains or airplanes)?		
3. Do you avoid or feel 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?		
4. Are there other things or situations of which you are extremely fearful, such as flying, seeing blood, getting an injection, heights, small enclosed places, or certain kinds of animals or insects?		
If yes, please specify:		
5. In the last six months, have you worried excessively more days than not about a number of future events or activities, and found it difficult to control that worry?		
6. Are you bothered by thoughts, impulses, or images that are extremely uncomfortable (e.g., hurting someone against your will or being contaminated by germs) and that keep coming back even when you try not to have them?		
7. Do you feel driven to continually repeat a behavior (e.g., washing, saying certain phrases in your mind, putting things in a particular order or checking locks, stoves, lights, etc.) and have difficulty resisting the urge to do so?		
8. Have you ever experienced or witnessed an event that involved actual or threatened death or serious injury to yourself or another person?		
If yes, did your response to the event involve intense fear, helplessness or horror?		

	Yes	No
9. Have you ever experienced sexual abuse or assault?		
10. Have you ever had sexual contact with someone that you did not want?		

Section IV: Other

	Yes	No
1. Have you had any unusual experiences such as hearing or seeing things that other people did not seem to hear or see?		
2. Have you ever believed that people were spying on you, out to get you, making plans to hurt you, or following you?		
3. Have you ever believed that people were sending you special messages through the newspaper, radio, TV or internet?		
4. Over the last several years, have you frequently gone to see your physician for physical problems?		
5. Do you frequently worry that you have a serious medical problem even when a doctor tells you otherwise?		
6. Are you preoccupied with a perceived defect in your appearance (e.g., your height, the shape of your nose, amount of hair loss, your complexion)?		
7. Have you ever had a time when you weighed much less than other people thought you ought to weigh?		
If yes, at that time were you very afraid that you could become fat?		
8. Have you often had times when you felt your eating was out of control?		
9. Have you ever made yourself vomit, used laxatives, or exercised a lot to prevent weight gain?		
10. Do you have a history of difficulties with paying attention, being easily distracted, losing things or organizing tasks or activities?		
11. Do you have a history of 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 first without thinking?		
12. Do you experience problems with 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?		