NAME: _____DATE: _____

Please indicate if you are currently experiencing any of the symptoms or conditions below by circling whichever apply:

Feeling sad / depressed	Crying frequently	Diminished interest in pleasure
Insomnia / hypersomnia	Change in eating pattern	Diminished capacity to concentrate
Feelings of guilt / worthlessness	Feeling helpless / hopeless	Thoughts of death / suicide
Thoughts of homicide	Extreme mood swings	Manic, elevated mood
Panic attack(s)	Anxiety and/or Phobia	Post-Traumatic Stress Disorder
Anorexia	Bulimia / binge eating	Anger or Rage
Explosive outbursts	Pathological gambling	Sexually compulsive behaviors
Other compulsive behaviors	Impulsive thoughts	Paranoia
Hallucinations	Delusions	Dissociation
Substance abuse	Self-harming	Other

If you currently are not experiencing any of the above symptoms or conditions, but have prior experience of these, please list below:

_____

_____

_____

Signed: _____