PCBHS

Name:_______________________________ **Date of Birth:**__________ **Date:**___________

Physician You're Seeing Today: ________________________________

1. For each item, please check the "YES" column if you've experienced the problem in the past 4 weeks. Check the "NO" column if you have not.

YES	NO	
		Little interest or pleasure in almost all activities
		Feeling sad or depressed
		Feeling tired or sleepy during the day
		Sleeping too much or too little
		Eating too much or too little, or losing control of how much you eat
		Forcing yourself to vomit after eating
		Believing you're too fat or too ugly, even though others say you're not
		Trouble concentrating or being easily distracted
		Being fidgety, restless, nervous, or tense
		Wishing you were dead or wanting to harm yourself
		Several days feeling "on top of the world" or highly energetic for no obvious reason
		Difficulties with stress, anger, or frustration
		Sudden panic or anxiety attack
		Worrying a lot
		Avoiding or dreading being around people or the center of attention
		Intrusive, disturbing thoughts or images that pop in your mind
		Doing or thinking something over and over to get rid of an unpleasant feeling
		Nightmares or disturbing daytime memories of a past unpleasant event
		Use of alcohol or drugs that you later regretted
		Trouble with your sex life
		Trouble with your memory or thinking
		Seeing, hearing, or believing things that others view as odd or unbelievable
		Difficulties coping with a medical condition or major life event
		Difficulties with family members or others who are upset with your behavior
		Other habit or behavior (e.g., gambling, unprotected sex, spending money) that is potentially harmful or that causes difficulties for you or someone else
		Other Problems? (please explain):

2. If you checked "YES" for any of the problems, to what extent have these problems caused you distress or interfered with your ability to do things? (circle one)

None	*A Little*	*Somewhat*	*A Lot*	*A Whole Lot*