Health Concern Screening- Clinical

Name:_____ Age: _____ Date: _____

1. Y N Are you currently under a doctor's care? If yes, for what.

2. Y N Are you currently taking medications or supplements? Please list.

3. Y N Have you ever taken medications for depression or anxiety? If yes, please list the medications, dosage, effectiveness and time period.

4. Y N Are you often irritable?
5. Y N Do you experience mood swings?
6. Y N Do you often feel inadequate or worthless?
7. Y N Do you have difficulty sleeping?
8. Y N Do you seem to feel sad or "blue" for no reason?
9. Y N Has there been a change in your appetite/increase or decrease?
10. Y N Do you think you are depressed?
11. Y N Do you have difficulty coping with stress?
12. Y N Have you ever been suicidal?
13. Y N Do you currently have suicidal thoughts?
14. Y N Do you have difficulty talking about your feelings?
15. Y N Do you exercise on a regular basis? If yes, please describe? If no, briefly explain the reason.

16. Y N Are you over weight? If yes, By how many pounds?
17. Y N Are you often anxious, but can't seem to identify why?
18. Y N Have you ever had a panic attack?
19. Y N Do you have any phobias?
20. Y N Do you have any obsessions or compulsions?
21. Y N Do you have problems controlling your anger?
22. Y N Do you use tobacco? Smoke Chew? How much?
23. Y N Do you use illegal drugs? What? How often?
24. Y N Do you drink coffee/tea/caffeine drinks? How much?
25. Y N Do you drink alcohol? How much alcohol do you drink a day?
26. Y N Has alcohol or drugs ever caused a problem for you?
27. Y N Do you have chronic pain? If yes, where?
28 Y N Do you have concerns with your marriage or relationship?
29. Y N Do you have problems with your children?
30. Y N Are you experiencing financial or employment problems? Please explain.