Self-Rated Symptom Measure & History—Adult

Name: _____ Age: ____ Sex: ❑ Male ❑ Female Date of birth: _____

Name of identified patient's primary care **doctor** or psychiatrist: _____
Do you want your doctor(s) to be aware of your contact with us? ❒Yes ❒ No. Initials: _____
If yes, please give: Fax: _____, Phone: _____ Address: _____
Ask office staff for a ***Release of Information*** form to specify information you would like sent.

Instructions: Use the numbers 0 – 4 to describe how much (or how often) you have been bothered by each problem **during the past TWO (2) WEEKS**: **0** = Not at all; **1** = rarely; **2** = several days; **3** = often; **4** = always

	0,1,2,3,4		0,1,2,3,4
F33.1 F32.9 F34.1 I. 1. Little interest or pleasure in doing things.		VIII. 14. Problems with sleep that affected your sleep quality over all.	
2. Feeling down, depressed, or hopeless.		IX. 15. Problems with memory (e.g., learning new information) or with location (finding your way home).	
II. 3. Feeling more irritated, grouchy, or angry than usual.			
F31.1 F31.9 III. 4. Sleeping less than usual, but still have a lot of energy.		X. 16. Unpleasant thoughts, urges, or images that repeatedly enter your mind.	F42.2
5. Started lots more projects than usual or did more risky things than usual.		17. Feeling driven to repeat behaviors or thoughts over and over.	F42.1
F41.1 F41.9 F43.23 IV. 6. Felt nervous, anxious, worried frightened, or on edge.		XI. 18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories.	F44.9
7. Felt panic or fear.		XII. 19. Not knowing who you really are or What you want out of life.	
F41.0 F43.10 Bothered by memories of trauma			
F40.01 8. Avoided situations that made you anxious.		20. Not feeling close to other people or Enjoying relationships with them.	
V. 9. Unexplained aches and pains (e.g., Head, back, joints, abdomen, legs)?		XIII. 21. Drinking at least 4 drinks of any kind of alcohol in a single day.	F10
10. Feeling that your concerns are not being taken seriously enough.		22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco.	F17
F45.85 VI. 11. Thoughts of hurting yourself. Number of past suicide attempts: ____		23. Used medicine without a doctor's prescription or in greater amounts or longer than prescribed [like Vicodin, Ritalin, Adderall, sleeping pills, or Xanax], OR, Using marijuana, cocaine or crack, LSD, ecstasy, heroin, inhalants, or methamphetamine.	F11-F18
F20.9 VII. 12. Hearing things other people cannot hear, like voices even when no one was around.			
F22 13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?		24. **Do you have guns in the home?**	

Adapted from **American Psychiatric Association** (2013).

a. For each of the above items marked, please explain **diagnosis and treatment**: _____
_____
_____

b. List any **prescribed medication** you are now taking, including dosages if known: _____
_____

c. List any medication to which you are allergic: _____or ❒ **NKA**

d. Give approximate dates of any previous **hospitalizations**, including psychiatric: _____
_____

e. Give approximate dates of **previous counseling**, including supervisory referrals: _____
_____

f. Rate Good (G) Fair (F) Poor (P): **Health** ___, **Family life** ___, **School performance** ___, **social support** ___, **housing** ___, **finances** ___. List **current health problems**: _____
_____

g. Do **family members** have ❒ 1. Psychosis, ❒ 2. Depression, ❒ 3. ADHD, ❒ 3. obsessions/ compulsions, ❒ 5. Substance abuse? Relationship:_____

Which do you most value (choose one group):
(1) Respect, control, comfort; (2) Bonding, approval, recognition; (3) Safety, certainty, preparedness
Are you more likely to handle problems by:
(a) Talking to others or using substances; (b) Taking time for yourself alone; (c) either a or b