

Name: _____

Date: _____

Adult Symptom Screener

Please check the box for the answer that best fits your experience.

PART 1: In the last 2 weeks, how often have you been bothered by the following problems?

	Not at all	Several days	More than half the days	Nearly every day
Feeling down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PART 2: In the last 2 weeks, how often have you been bothered by the following problems?

	Not at all	Several days	More than half the days	Nearly every day
Feeling nervous, anxious or on edge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Not being able to stop or control worrying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PART 3: The following questions relate to your experiences over the last 6 months.

	Yes	No
In the past 6 months, did you ever have a spell or an attack when all of sudden you felt frightened, anxious or very uneasy?	<input type="checkbox"/>	<input type="checkbox"/>
In the past 6 months, did you ever have a spell or attack when for no reason your heart suddenly began to race, you felt faint, or you couldn't catch your breath?	<input type="checkbox"/>	<input type="checkbox"/>
Did any of these spells or attacks ever happen in a situation when you were not in danger or not the center of attention?	<input type="checkbox"/>	<input type="checkbox"/>

PART 4: Please respond to the degree that the following problems have bothered you during the past week.

	Not at all	A little bit	Somewhat	Very much	Extremely
Fear of embarrassment causes me to avoid doing things or speaking to people.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I avoid activities in which am the center of attention.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Being embarrassed or looking stupid are among my worst fears.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PART 5: Please answer each question to the best of your ability.

	Yes	No
Have you experienced any of the following traumatic events: natural disaster (e.g. flood, hurricane, tornado, earthquake), fire, explosion, or industrial accident; transportation accident (e.g. car accident, plane crash); physical assault (e.g. being attacked, beaten up); sexual assault (e.g. rape, attempted rape, made to perform any type of sexual act through force or threat of harm); captivity or exposure to a war-zone; life threatening illness or injury; sudden, unexpected death of or injury to someone close to you; or serious injury, harm, or death to someone else that you witnessed or caused?	<input type="checkbox"/>	<input type="checkbox"/>
Has this event caused any significant problems or symptoms that lasted for more than a month?	<input type="checkbox"/>	<input type="checkbox"/>

PART 6: Please answer each question to the best of your ability.

Has there ever been a period of time when you were not your usual self and...	Yes	No
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	<input type="checkbox"/>	<input type="checkbox"/>
...you were so irritable that you shouted at people or started fights or arguments?	<input type="checkbox"/>	<input type="checkbox"/>
...you felt much more self-confident than usual?	<input type="checkbox"/>	<input type="checkbox"/>
...you got much less sleep than usual and found you didn't really miss it?	<input type="checkbox"/>	<input type="checkbox"/>
...you were much more talkative or spoke much faster than usual?	<input type="checkbox"/>	<input type="checkbox"/>
...thoughts raced through your head or you couldn't slow your mind down?	<input type="checkbox"/>	<input type="checkbox"/>
...you were easily distracted by things around you that you had trouble concentrating or staying on track?	<input type="checkbox"/>	<input type="checkbox"/>
...you had much more energy than usual?	<input type="checkbox"/>	<input type="checkbox"/>
...you were much more active or did many more things than usual?	<input type="checkbox"/>	<input type="checkbox"/>
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	<input type="checkbox"/>	<input type="checkbox"/>
...you were much more interested in sex than usual?	<input type="checkbox"/>	<input type="checkbox"/>
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	<input type="checkbox"/>	<input type="checkbox"/>
...spending money got you or your family into trouble?	<input type="checkbox"/>	<input type="checkbox"/>

PART 7: The following questions relate to your eating habits.

	Yes	No
When you eat, do you make yourself sick because you feel uncomfortably full?	<input type="checkbox"/>	<input type="checkbox"/>
Do you ever worry that you have lost control over how much you eat?	<input type="checkbox"/>	<input type="checkbox"/>
Have you recently lost more than 14 pounds in a 3 month period?	<input type="checkbox"/>	<input type="checkbox"/>
Do you believe yourself to be fat when others say you are too thin?	<input type="checkbox"/>	<input type="checkbox"/>
Would you say that food dominates your life?	<input type="checkbox"/>	<input type="checkbox"/>

PART 8: Please answer the following question to the best of your ability.

	Yes	No
Have you ever been bothered by having to perform some ritual or act over and over that does not make sense?	<input type="checkbox"/>	<input type="checkbox"/>

PART 9: The following questions relate to your alcohol and substance use.

	Never	Monthly or less	2 to 4 times a month	2 to 3 times a week	4 or more times a week
How often do you have a drink of Alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	1 to 2	3 to 4	5 to 6	7 to 9	10 or more
How many drinks containing alcohol do you have on a typical day when you are drinking?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
Being embarrassed or looking stupid are among my worst fears.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PART 10: Please answer the following question to the best of your ability.

	Yes	No
In the past year have you used an illegal drug or used a prescription medication for non-medical reasons?	<input type="checkbox"/>	<input type="checkbox"/>

PART 11: Please answer the questions below, rating yourself on each of the criteria shown using the scale provided. As you answer each question, select the option that best describes how you have felt and conducted yourself over the past 6 months.

	Never	Rarely	Sometimes	Often	Very Often
How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you have difficulty getting things in order when you have to do a task that requires organization?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you have problems remembering appointments or obligations?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
When you have a task that requires a lot of thought, how often do you avoid or delay getting started?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you feel overly active and compelled to do things, like you were driven by a motor?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PART 12: The questions listed below relate to your thoughts and feelings. If the way you have been in recent weeks or months differs from the way you usually are, please answer based on when you were your usual self.

	Yes	No
Do you find that most people will take advantage of you if you let them know too much about you?	<input type="checkbox"/>	<input type="checkbox"/>
Do you generally feel nervous or anxious around people?	<input type="checkbox"/>	<input type="checkbox"/>
Do you avoid situations where you have to meet new people?	<input type="checkbox"/>	<input type="checkbox"/>
Do you avoid getting to know people because you're worried that they may not like you?	<input type="checkbox"/>	<input type="checkbox"/>
Has avoidance of getting to know people due to fear of being disliked affected the number of friends that you have?	<input type="checkbox"/>	<input type="checkbox"/>
Do you keep changing the way you present yourself to people because you don't know who you really are?	<input type="checkbox"/>	<input type="checkbox"/>
Do you often feel like your beliefs change so much that you don't know what you believe any more?	<input type="checkbox"/>	<input type="checkbox"/>
Do you often get angry or irritated because people don't recognize your special talents or achievements as much as they should?	<input type="checkbox"/>	<input type="checkbox"/>

PART 13: Please answer the following question to the best of your ability.

	Yes	No
Have you had any unusual experiences such as hearing voices, seeing visions, or having ideas you later found out were not true?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any other experiences, such as mind reading, ESP, thoughts being controlled by others, seeing things on TV that refer to you specifically?	<input type="checkbox"/>	<input type="checkbox"/>