

## ADULT SYMPTOM SCREENING FORM

Date Completed: \_\_\_\_\_

Completed by: \_\_\_\_\_

Please darken a circle to reflect your behavior or feelings over the past two weeks.

**Fill in the circle that best describes you:**

	<i>Never</i>	<i>Sometimes</i>	<i>Often</i>
1. Lost temper	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Felt angry or resentful	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Drank three or more alcoholic drinks within 3 hours	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Got physical in a fight or wanted to hurt someone	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Behavior caused work or relationship problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Felt unhappy or sad	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. Felt worthless or inferior	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. Worries prevented you from doing things	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. Felt lonely, unwanted or unloved	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. Changed moods quickly	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. Made careless mistakes doing work or tasks	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. Had difficulty organizing tasks, time or belongings.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13. Was forgetful in daily activities (needed reminders).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. Felt less able to enjoy the things you usually enjoy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15. Had spells or attacks when you suddenly felt anxious, frightened, or uneasy, even when others would not feel that way.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16. Felt hyper, driven to do something, or restless	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17. Had thoughts of ending your life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18. Used illicit drugs (If so describe: _____)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
19. Had difficulties sleeping well	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20. Had a change in your appetite	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>