Patient ID: Site: Date: 10/16/2020

We want your input about how you are doing. Please answer honestly and to the best of your ability. Your provider can help you with the survey if you prefer.

In the past month how often have you:	Not at All in the Past Month	Once in the Past Month	Several Times in the Past Month	Several Times a Week in the Past Month	Every Day in the Past Month
felt nervous, tense, worried, frustrated, or afraid?	❍	❍	❍	❍	❍
felt depressed?	❍	❍	❍	❍	❍
felt lonely?	❍	❍	❍	❍	❍
been told by others that you acted “paranoid” or “suspicious”?	❍	❍	❍	❍	❍
heard voices, or heard or seen things that other people didn’t think were there?	❍	❍	❍	❍	❍
had trouble making up your mind about something, like deciding where you wanted to go or what you wanted do, or how to solve a problem?	❍	❍	❍	❍	❍
had trouble thinking straight, concentrating on something you needed to do like worrying so much, or thinking about a problem so much that you can’t remember or focus on other things?	❍	❍	❍	❍	❍
felt that your behavior or actions were strange or different from that of other people?	❍	❍	❍	❍	❍
felt out of place, or like you did not fit in?	❍	❍	❍	❍	❍
forgot important things?	❍	❍	❍	❍	❍
had problems with thinking too fast (thoughts racing)?	❍	❍	❍	❍	❍
felt suspicious or paranoid?	❍	❍	❍	❍	❍
felt like hurting or killing yourself?	❍	❍	❍	❍	❍
felt like seriously hurting someone else?	❍	❍	❍	❍	❍

For Office Use Only – Clinicians, please review this form with your client and mark below.
Was this form reviewed with the client during today’s appointment? _____Yes _____No

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