NAME_____

Anxiety and Mood Disorders Screening Tool

Section 1: PD	Y	N
Have you, on more than one occasion, had spells or attacks when you suddenly felt anxious, frightened, uncomfortable or uneasy, even in situations where most people would not feel that way? Did the spells peak within 10 minutes? (If yes to either please mark Yes) **If you marked no, then proceed to Section 2.**		
At any time in the past, did any of these spells or attacks come on unexpectedly or occur in an unpredictable or unprovoked manner?		
Have you ever had one such attack followed by a month or more of persistent fear of having another attack, or worries about the consequences of an attack?		
During the worst attacks that you can remember did you have:		
Skipping, racing or pounding heart?		
Sweating or clammy hands?		
Trembling or shaking?		
Shortness of breath or difficulty breathing?		
Choking sensations or a lump in your throat?		
A fear that you were dying?		
Sensations that things around you felt strange, unreal, detached or unfamiliar, or did you feel outside of or detached from, part or all of your body?		
Hot flushes or chills?		
Chest pain, pressures, or discomfort?		
Nausea, stomach problems or sudden diarrhea?		
Tingling or numbness in parts of your body?		
Dizzy, unsteady, lightheaded, or faint?		
A feeling that you were losing control or going crazy?		

Section 2: SP	Y	N
In the past month, were you fearful or embarrassed of being watched, being the focus of attention, or fearful of being humiliated? This includes things like speaking in public, eating in public or with others, writing while someone watches or being in social situations. **If your answers to this question are no, then proceed to Section 3.**		
Is this fear excessive or unreasonable?		
Do you fear these situations so much that you avoid them or suffer through them?		
Does this fear disrupt your normal work or social functioning or cause you significant distress?		
Section 3: BDD		
Have you, for a prolonged period of time, been excessively preoccupied with thoughts that a feature of your physical appearance is abnormal, ugly, or unacceptable? **If no, move on to section 4.**		
Does this preoccupation result in significant distress or interrupt your normal work or social functioning?		
Section 4: Tricotillomania		
Have you ever, for an extended period of time, pulled out hairs from your body (scalp hair, eyelashes, eyebrows, pubic hair, or other hairs on your body) such that you had noticeable hair loss or the need to conceal your hair loss. **If no, move on to section 5.**		
Do you have an increased sense of tension immediately before pulling out the hair or when trying to resist pulling?		
Do you receive pleasure, gratification or relief when pulling out the hair?		
Do the hair pulling and its consequences result in significant distress or impair your social or work life?		

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Section 5: GAD	Y	N	Section 6: OCD	Y	N
Have you worried excessively or been anxious about two or more things (for example; finances, children's well being, misfortune, work, family, or friends) over the past 6 months? More than others would? Are these worries present more days than not? **If your answers to this question are no, then proceed to section 6.**			1. In the past month have you been bothered by recurrent thoughts, impulses, or images that were unwanted, distasteful, inappropriate, intrusive, or distressing? (For example, the idea that you were dirty, contaminated or had germs, or a fear of contaminating others. Fears or images of harming someone even though you didn't want to. A fear that you would act on some other impulse that you do not want to do. Fears or superstitions that you would be responsible for things going wrong. An obsession with sexual thoughts, images or impulses. Obsessions about religion or an obsession that is totally against your religion. Hoarding or collecting things that you have difficulty disposing of to a degree that is unreasonable.) **If no, then skip to question #4 in this section.**		
Do you find it difficulty to control the worries or do they interfere with your ability to focus on what you are doing?			2. Did they keep coming back into your mind even when you tried to ignore or get rid of them?		
When you were anxious over the past 6 months did you, most of the time:			3. Do you think that these obsessions are the product of your own mind and that they are not imposed from the outside?		
Feel restless, keyed up or on edge?			4. In the past month, did you do something repeatedly without being able to resist doing it, like washing or cleaning excessively, counting or checking things over and over, or repeating, collecting, arranging things, or other superstitious rituals? **If your answer to this question is no, then skip to section 7.**		
Feel tense?			5. Did you recognize that either these obsessive thoughts or these compulsive rituals were excessive or unreasonable?		
Have difficulty sleeping (difficulty falling asleep, waking in the middle of the night, early morning awakening or sleeping excessively)?			6. Did these obsessive thoughts or compulsive behaviors significantly interfere with your normal routine, occupational functioning, usual social activities, or relationships, or did they take more than one hour?		
Have difficulty concentrating or find your mind going blank?			[redacted]	[redacted]	[redacted]
Feel irritable?			[redacted]	[redacted]	[redacted]
Feel tired, weak, or exhausted easily?			[redacted]	[redacted]	[redacted]

NAME_____

Section 7: PTSD	Y	N	Section 8: Depression	Y	N
Have you ever experienced or witnessed or had to deal with an extremely traumatic event that included actual or threatened death or serious injury to you or someone else? **If no, proceed to section 8.**			Have you been consistently depressed or down, most of the day, nearly every day, for the past two weeks?		
During the past month, have you re-experienced that event in a distressing way (such as dreams, intense recollections, flashbacks" or physical reactions)?			In the past two weeks, have you been less interested in most things or less able to enjoy the things you used to enjoy most of the time? **If your answers to both questions above are no, then skip to section 9.**		
In the past month:			**Over the past two weeks, when you felt depressed or uninterested:**		
Have you avoided thinking about the event or things that remind you of the event?			Was your appetite decreased or increased nearly every day?		
Have you had trouble recalling some important part of what happened?			Did your weight decrease or increase without intentionally trying?		
Have you become less interested in hobbies or social situations?			Did you have trouble sleeping nearly every night (difficulty falling asleep, waking up in the middle of the night, early morning wakening, or sleeping excessively)?		
Have you felt detached or estranged from others?			Did you talk or move more slowly than normal or were you fidgety, restless or having trouble sitting still almost every day?		
Have you noticed that your feelings are numbed?			Did you feel tired or without energy almost every day?		
Have you felt that your life would be shortened because of this trauma?			Did you have difficulty concentrating or making decisions almost every day?		
Have you had difficulty sleeping?			Did you feel worthless or guilty almost every day?		
Were you especially irritable or did you have outbursts of anger?			Did you repeatedly consider hurting yourself, feel suicidal, or wish that you were dead?		
Have you had difficulty concentrating?					
Were you nervous or constantly on guard?					
Were you easily startled?					

NAME_____

Section 9: BPD	Y	N
Do you ever feel that you have moods that cycle more rapidly than most people with at least some periods where your mood is elevated substantially beyond your normal mood?		
Have you ever had at least a four-day period of sustained, excessively elevated mood, with rapid thinking, many new ideas, heightened interest in sex and loss of sleep?		
Have you ever had at least a four-day period of sustained, excessively irritable mood, with anger, arguments, or breaking things that led to difficulties with others?		
Section 10		
Have you ever been a victim of physical abuse or domestic violence?		
Have you ever been a victim of sexual abuse?		
Do you have a significant fear of gaining weight or becoming fat?		
Have you ever used diet pills, laxatives or water pills to control weight?		
Do you have a history of binge eating (eating large amounts of food over a short period of time)?		
Have you ever induced vomiting to control your weight?		
Have you been worried about changes in your memory?		
Have you ever had difficulty with drinking more alcohol or using more drugs than you intended to?		
Has using alcohol or drugs ever resulted in problems with family or friends?		
Have you ever had unpredictable or violent behavior when using alcohol or drugs?		
Have you ever tried to stop using alcohol or drugs and found that you could not stop?		
Have you ever had job, legal, or financial problems related to alcohol or drug use?		
Have you ever had any physical symptoms such as sweating, shaking, rapid heartbeat, increased blood pressure, confusion or seizures when trying to stop drinking alcohol?		

Section 10	Y	N
Do you have a history of self-destructive behavior?		
Do you have frequent violent thoughts about harming other people or destroying property?		
Have you ever been violent towards other people or towards property?		
Do you believe that you have had repeated difficulties maintaining a job?		
Do you believe that you have had repeated difficulties maintaining close relationships?		
Do you have concerns about your sexual orientation?		
Do you have concerns about your sexual performance?		

Please circle one number for each of the following three questions:

1. **To what extent have emotional symptoms disrupted your work in the last month?**

0 1 2 3 4 5 6 7 8 9 10
none mildly moderately mostly extremely

2. **To what extent have emotional symptoms disrupted your social life in the last month?**

0 1 2 3 4 5 6 7 8 9 10
none mildly moderately mostly extremely

3. **To what extent have emotional symptoms disrupted your family life/home responsibilities in the last month?**

0 1 2 3 4 5 6 7 8 9 10
none mildly moderately mostly extremely