STRESS & ANXIETY SCREENING

In the past month, have you had any of the following? If **yes**, rate the level of discomfort from 1-4 (**1**= slightly uncomfortable, **2**=uncomfortable, **3**=very uncomfortable, **4**=panicky)

		Yes	Level of Discomfort
1.	Shortness of breath	_____	_____
2.	Choking	_____	_____
3.	Accelerated heart rate	_____	_____
4.	Chest pain or discomfort	_____	_____
5.	Sweating	_____	_____
6.	Dizziness, unsteady feeling, or faintness	_____	_____
7.	Nausea or abdominal distress	_____	_____
8.	Feelings of unreality (out of your body)	_____	_____
9.	Numbness or tingling sensations (usually in the fingers, toes, or lips)	_____	_____
10.	Hot flashes or chills	_____	_____
11.	Fear of becoming seriously ill or dying	_____	_____
12.	Fear of going crazy	_____	_____
13.	Fear of losing control and doing something that might harm or embarrass yourself or others	_____	_____
14.	Trembling or shaking	_____	_____

What is the frequency of occurrence of the above items? _____
(**1**=once a month or less, **2**=once per week, **3**=two or more times per week, **4**=one or more times daily)

To what degree do these feelings interfere with your life? _____
(**1**=none, **2**=slight, **3**=moderate, **4**=considerable, **5**=severe)

DEPRESSION SCREENING

In the past month:	Points: **0** No	**1** Sometimes	**2** Most of the time	**3** All of the time
1. Do you feel sad?	_____	_____	_____	_____
2. Do you feel pessimistic about the future?	_____	_____	_____	_____
3. Do you feel like a failure?	_____	_____	_____	_____
4. Do you feel guilty?	_____	_____	_____	_____
5. Do you feel less pleasure from the things you used to enjoy?	_____	_____	_____	_____
6. Do you feel you are being punished?	_____	_____	_____	_____
7. Do you feel disappointed in yourself?	_____	_____	_____	_____
8. Do you feel self-critical?	_____	_____	_____	_____
9. Do you have suicidal thoughts or wishes?	_____	_____	_____	_____
10. Do you feel like crying?	_____	_____	_____	_____
11. Do you feel agitated?	_____	_____	_____	_____
12. Do you have a difficult time making decisions?	_____	_____	_____	_____
13. Do you feel worthless?	_____	_____	_____	_____
14. Do you feel loss of energy?	_____	_____	_____	_____
15. Do you feel irritable?	_____	_____	_____	_____
16. Do you have difficulty concentrating?	_____	_____	_____	_____
Subtotal	_____	_____	_____	_____

	Points: **0** NO	**1** YES
17. Has your general health changed?	____	____
18. Have you gained or lost weight?	____	____
19. Do you sleep more or less than you used to?	____	____
20. Has your interest in sex and/or libido changed?	____	____
Subtotal	____	____

TOTAL _____