Advanced Healthcare *Associates*

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Patient's Name: ________________________________ DOB:________________ Date: ____________

SECTION I

NO	YES	
[ ]	[ ]	1. Have you been consistently depressed or down, more of the day, nearly every day, for the past two weeks?
[ ]	[ ]	2. 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 answer to both questions above is "NO", please proceed to Section II without answering questions 3.

3. Over the past two weeks, when you felt depressed or uninterested:

NO	YES	
[ ]	[ ]	a. Was your appetite decreased or increased nearly every day? Did your weight decreased or increase or increase without trying intentionally (+/- 5% of body weight or +/- 3.5 kg for a 160lbs/70 kg person in a month)? (If yes to either, please check YES).
[ ]	[ ]	b. 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)?
[ ]	[ ]	c. Did you talk or move more slowly than normal or were you fidgety, restless or having trouble sitting still almost every day?
[ ]	[ ]	d. Did you feel tired or without energy almost every day?
[ ]	[ ]	e. Did you feel worthless or guilty almost every day?
[ ]	[ ]	f. Did you have difficulty concentrating or making decisions almost every day?
[ ]	[ ]	g. Did you repeatedly consider hurting yourself, feel suicidal, or wish that you were dead?

SECTION II

NO	YES	
[ ]	[ ]	1. In the past 12 months, have you had 3 or more alcoholic drinks within a 3 hour period on 3 or more occasions?

If your answer to this question is "no", you have completed Section II – please do not answer the questions below. Please go to Section III.

2. In the past 12 months:

NO	YES	
[ ]	[ ]	a. Did you need to drink more in order to get the same effect as when you first started drinking?
[ ]	[ ]	b. When you cut down on drinking did your hands shake, did you sweat of feel agitated? Did you drink to avoid these symptoms? (If yes to either please check "YES".)

SECTION II

NO	YES	
[ ]	[ ]	c. During the times when you drank alcohol, did you end up drinking more than you planned when you started?
[ ]	[ ]	d. Have you tried to reduce or stop drinking alcohol but failed?
[ ]	[ ]	e. On the days that you drank, did you spend substantial time in obtaining alcohol, drinking, or in recovering from the effects of alcohol?
[ ]	[ ]	f. Did you spend less time working, enjoying hobbies, or being with others because of your drinking?
[ ]	[ ]	g. Have you continued to drink even though you knew that it caused you problems?

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SECTION III

NO	YES	
[ ]	[ ]	1. 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 check "YES".)
[ ]	[ ]	2. At any time in the past, did any of those spells or attacks come on unexpectedly or occur in an unpredictable or unprovoked manner?

If your answer to both questions above is "NO", please proceed to Section IV without answering any other questions below in Section III.

NO	YES	
[ ]	[ ]	3. Have you even had one such attach followed by a month or more of persistent fear of having another attack, or worries about the consequences of the attack?
[ ]	[ ]	4. During the worst spell that you can remember:
[ ]	[ ]	a. Did you have skipping, racing or pounding of your heart?
[ ]	[ ]	b. Did you have sweaty or clammy hands?
[ ]	[ ]	c. Were you trembling or shaking?
[ ]	[ ]	d. Did you have shortness of breath or difficulty breathing?
[ ]	[ ]	e. Did you have a choking sensation or lump in your throat?
[ ]	[ ]	f. Did you have chest pain, pressure, or discomfort?
[ ]	[ ]	g. Did you have nausea, stomach problems, or sudden diarrhea?
[ ]	[ ]	h. Did you feel dizzy, unsteady, lightheaded, or faint?
[ ]	[ ]	i. Did things around you feel strange, unreal, detached or unfamiliar, or did you feel outside of or detached from part or all of your body?
[ ]	[ ]	j. Did you fear that you were losing control or going crazy?

SECTION III

NO	YES	
[ ]	[ ]	k. Did you fear that you were dying?
[ ]	[ ]	l. Did you have tingling or numbness in parts of your body?
[ ]	[ ]	m. Did you have hot flashes or chills?
[ ]	[ ]	5. In the past month, did you have such attacks repeatedly (two or more) followed by persistent fear of having another attack?

SECTION IV

NO	YES	
[ ]	[ ]	1. In the past month, were you fearful of or embarrassed by being watched or being the focus of attention, or fearful of being humiliated? This includes things like speaking in public, eating in public alone or with others, writing while someone watches, or being in social situations?
[ ]	[ ]	2. Is this fear excessive or unreasonable?
[ ]	[ ]	3. Do you fear these situations so much that you avoid them or suffer through them?
[ ]	[ ]	4. Does this fear disrupt your normal work or social functioning or cause you significant distress?

SECTION V

NO	YES	
[ ]	[ ]	1. Have you had excessive anxiety and worry, occurring more days than not for at least six months, about a number of events or activities (such as work or school performance)?
[ ]	[ ]	2. Did you find it difficult to control the worry?

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If you answered "no" to question 1 or 2 in this section, you are finished with this form. If you answered "yes" please answer these last two questions. Thank you!

[ ] [ ] 3. During that six months, which of the following symptoms were present for more days than not?

[ ] [ ] a. restlessness or feeling keyed up or on edge
[ ] [ ] b. being easily fatigued
[ ] [ ] c. difficulty concentrating or mind going blank
[ ] [ ] d. irritability
[ ] [ ] e. muscle tension
[ ] [ ] f. sleep disturbance (difficulty falling or staying asleep, or restless, unsatisfying sleep)

[ ] [ ] 4. Do the anxiety, worry, or physical symptoms disrupt your normal work or functioning, or cause you significant distress?

YES/NO **Please answer each question to the best of your ability**

[ ] [ ] 1. Has there ever been a period of time when you weren't your usual self and 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?

[ ] [ ] You were so irritable that you shouted at people or started fights or arguments?

[ ] [ ] You felt much more self-confident than usual?

[ ] [ ] You got much less sleep than usual and found that you didn't really miss it?

[ ] [ ] You were more talkative or spoke much faster than usual?

[ ] [ ] Thoughts race through your head or you couldn't slow your mind down?

[ ] [ ] You were so easily distracted by things around you that you had trouble concentrating or staying on track?

[ ] [ ] You had much more energy than usual?

[ ] [ ] You were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?

[ ] [ ] You were much more interested in sex than usual?

[ ] [ ] You did things that were unusual for you or that other people might have thought were excessive, foolish or risky?

[ ] [ ] Spending money got you or your family in trouble?

[ ] [ ] 2. If you checked YES to more than one of the above, have seven of these ever happened during the same period of time?

3. How much of a problem did any of these cause you – like being able to work; having family, money or legal troubles; getting into arguments or fights?

[ ] No problem [ ] Minor problem [ ] Moderate problem [ ] Serious problem

[ ] [ ] 4. Have any of your blood relatives (i.e., children, sibling, parents, grandparents, aunts and uncles) had manic-depressive illness or bipolar disorder

[ ] [ ] 5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?