Self-Rating Scale

Name: ______________________ Date: ______________

Are you following the treatment plan provided? (Medications, Therapy, Substance Abuse Treatment, etc.) ☐ Yes ☐ No

FOR WOMEN: Are you currently pregnant? ☐ Yes ☐ No Are you trying to get pregnant? ☐ Yes ☐ No
Are you nursing? ☐ Yes ☐ No Are you using birth control? ☐ Yes ☐ No
If yes, what type? (include name of medication) ______________________

How are the following issues or symptoms affecting your life right now?

Rate each symptom below: 0 = not present, 1 = very mild, 2 = mild, 3 = moderate, 4 = severe, 5 = extremely severe

	Circle the words that best describe how you are feeling		Since last time is this: Better	Worse	Same
1.	Depressed, sad, hopeless, feel worthless	0 1 2 3 4 5	☐	☐	☐
2.	Suicidal thoughts, want to hurt yourself, want to die	0 1 2 3 4 5	☐	☐	☐
3.	Hostile, angry, irritable, want to hurt others, fighting	0 1 2 3 4 5	☐	☐	☐
4.	Anxiety, worry, panic, fear, excessive tension	0 1 2 3 4 5	☐	☐	☐
5.	Obsessive thoughts, "stuck" thoughts, repetitive behavior	0 1 2 3 4 5	☐	☐	☐
6.	Elevated mood, extreme energy, euphoria, racing thoughts	0 1 2 3 4 5	☐	☐	☐
7.	Hallucinations, seeing/hearing things others can't, scary thoughts	0 1 2 3 4 5	☐	☐	☐
8.	Distractible, poor concentration, can't stay on task, can't focus	0 1 2 3 4 5	☐	☐	☐
9.	Confused, forgetful, problems communicating	0 1 2 3 4 5	☐	☐	☐
10.	Isolated, avoiding social contact	0 1 2 3 4 5	☐	☐	☐
11.	Insomnia, problems getting to sleep or staying asleep	0 1 2 3 4 5	☐	☐	☐
12.	Alcohol use	0 1 2 3 4 5	☐	☐	☐
13.	Drug use (list: ______________)	0 1 2 3 4 5	☐	☐	☐
14.	Smoking/Tobacco use	0 1 2 3 4 5	☐	☐	☐
15.	Neglecting your health, hygiene or nutrition	0 1 2 3 4 5	☐	☐	☐
16.	Reduction in energy level, fatigue, sluggish, can't get going	0 1 2 3 4 5	☐	☐	☐
17.	Involuntary muscle movements, tics, twitches, tremors	0 1 2 3 4 5	☐	☐	☐
18.	Other symptoms that are bothering you (list below):	0 1 2 3 4 5	☐	☐	☐

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19. New or chronic (ongoing) pain — 0 1 2 3 4 5 6 7 8 9 10
DESCRIBE: — No pain (0) · Moderate pain (5) · Worst possible pain (10)

List some of your major stressors:

____

____

Are there any other issues that you need to speak with your provider about? (List):

____

Have you had any new medical problems or started any new medications (including over-the-counter or herbal remedies) recently?
List: ______________________

REMINDER: Ask your provider if you need prescription refills, a work or school excuse, permission slips or other special requests. Some reports may require an additional charge for time spent.

DICTATION # ____________ Reviewed by: ____________ Date: ____________