

Clinical Self report form

Name: _____ ID# _____ Clinician: _____ Date / /

Since your last appointment:

Circle

- Has there been a period of time when you were feeling down or depressed most of the day, nearly everyday?** Yes No
 If Yes, Did it last as long as two weeks? Yes No
- What about being a lot less interested in most things or unable to enjoy things you usually enjoy?** Yes No
 If Yes, Did it last as long as 2 weeks? Yes No
- Has there been a period of time when your were feeling so good or so hyper people thought you were not your normal self or you were so hyper you got in trouble?** Yes No
 If Yes, Was it more than just feeling good? Yes No
 Did anyone say you were manic? Yes No
- What about a period of time when you were so irritable that you would shout at people or start fights or arguments?** Yes No
- Have you experienced a major stress that you feel has caused your mood to change?** Yes No
 if yes (describe) _____
- Have you experienced other medical problems?** Yes No
 if yes (describe) _____

Used additional psychiatric care/treatment Yes No Other medical treatment Yes No Onset of last menses ___/___/___

Over the past 10 days how many days have you been/had...

- ...depressed **most** of the day ___/10 Days ... unable to experience pleasure **most** of the day ___/10 Days
- ...**any** period of abnormal mood elevation ___/10 Days ...**any** period of abnormal irritability ___/10 Days
- ...**any** period of abnormal anxiety ___/10 Days

During the past week ...

- What is the least you have slept in any one day ___ hrs What is the most you have slept any one day ___ hrs
- Have you had: Panic Attacks ___ Binge/Purge ___ Headaches ___ Weight ___
- Indicate your use of: Caffeine ___ cups/day Nicotine ___ packs/day Alcohol ___ drinks/week Drugs _____

For each item rate this week compared to your usual (when well)	← ← ← ← ← Decreased					←Well→	Increased → → → → →				
	Constant and Severe	Nearly Every Day	Often	Rarely and/or mild	Rarely and/or mild	Normal	Often	Nearly Every Day	Often	Constant and Severe	
Sleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/> Normal	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ability to enjoy pleasant things / usual interests	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/> Normal	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Self confidence/Self Esteem	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/> Normal	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Energy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/> Normal	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ability to Concentrate	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/> Normal	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Distractibility						<input type="checkbox"/> None	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Appetite	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/> Normal	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Physical restlessness/ agitation						<input type="checkbox"/> None	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Rate of speech or thoughts	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/> None	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Feel life isn't worth living or suicidal thoughts						<input type="checkbox"/> None	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Talking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/> Normal	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Racing thoughts						<input type="checkbox"/> None	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Making plans or getting new projects started	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/> Normal	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Behaviors others regard as excessive, foolish or risky						<input type="checkbox"/> None	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please complete for all medications used since your last visit

Medication	Total daily dose	Mg missed this week	Comments / adverse effects	<input type="checkbox"/> Check if no adverse effects
_____	Mg	Mg		
_____	Mg	Mg		
_____	Mg	Mg		
_____	Mg	Mg		
_____	Mg	Mg		
_____	Mg	Mg		
_____	Mg	Mg		
_____	Mg	Mg		