Central Illinois Psychiatric Associates

Initial Screening with MD/NP

TODAY'S DATE: ____________________

NAME: ____

Male Female **AGE:** ____________________

Have you taken any medication in the last four weeks? Yes No

If YES, please list: ____

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Do you smoke cigarettes? Yes No

Recreation/Street Drug Use? Yes No

Alcohol Use? Yes No **If YES, frequency:** ____________________

Acute and/or Chronic Health Conditions being treated by your Primary Care Provider? Yes No

If YES, please list conditions (example: Asthma, High Blood Pressure, Diabetes, etc): ____________________

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Reason for Office Visit Today:

Check off any of the following symptoms which has been most bothersome and/or have occurred frequently during the last four weeks.

- Frequent crying/weeping
- Sad/Depressed/Down in the dumps
- Irritability
- Sleeping too much
- Freq negative thinking
- Memory problems
- Fatigue/Lack of energy
- Feeling life is not worth living
- Freq thoughts of death/suicide
- Lack of/loss of interest in things you previously found pleasure in
- Increase/Decrease in appetite
- Trouble making decisions
- Increase/Decrease in weight
- Agitation
- Constant worry
- Easily annoyed or irritable

- Mood swings
- Extreme irritability
- Racing thoughts
- Excessively "high" overly good mood
- Shopping sprees
- Little sleep needed
- Jump from one idea to another
- Distractibility
- Inability to concentrate
- Poor judgement
- Increased sexual drive
- Aggressive behavior
- Abuse of street drugs
- Fear of losing control
- Headaches
- Tension
- Restlessness
- Fearful feelings

- Shallow breathing
- Rapid heart rate or heart pounding
- Tremors, trembing, or shakiness
- Nervousness, muscle tension
- Fingernail biting, picking at skin
- Difficulty concentrating
- Poor attention, unfocused
- Easily startled
- Constantly "on guard"
- Dizziness/Lightheadedness
- Nausea
- Difficulty sleeping
- Sweating
- Diarrhea
- Keyed up/On edge
- Trouble relaxing

Other: ____

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