Over The Past Two Weeks Have You Experienced Any Of The Following Symptoms?

Use this scale: 0 = None 1= Infrequent 2= Sometimes 3= Most of the Time 4= All of the Time

1. Difficult with Sleep	0	1	2	3	4
2. Appetite/Weight Changes	0	1	2	3	4
3. Feeling Depressed/Dejected	0	1	2	3	4
4. Self-Critical, Condemning, Blaming	0	1	2	3	4
5. Loss of Interest/Pleasure	0	1	2	3	4
6. Loss of Sexual Interest	0	1	2	3	4
7. Thought of Death/Dying	0	1	2	3	4
8. Suicidal Thoughts	0	1	2	3	4
9. Staying by Yourself/Withdrawn	0	1	2	3	4
10. Energy Decrease	0	1	2	3	4
11. Anxiety	0	1	2	3	4
12. Panic Attacks	0	1	2	3	4
13. Being ill at Ease with Others	0	1	2	3	4
14. Trouble Keeping Conversations Going	0	1	2	3	4
15. Being Easily Embarrassed	0	1	2	3	4
16. Obsessive/Repetitive Thought or Behaviors	0	1	2	3	4
17. Nightmares/Bad Dreams	0	1	2	3	4
18. Headaches	0	1	2	3	4
19. Upset Stomach	0	1	2	3	4
20. Concentration/Attention Changes	0	1	2	3	4
21. Racing/Rapid Thoughts	0	1	2	3	4
22. Energy Increase	0	1	2	3	4
23. Feeling Too High or Elated	0	1	2	3	4
24. Irritability/Temper Control	0	1	2	3	4
25. Feeling More Impulsive	0	1	2	3	4
26. Feeling More Self Confident	0	1	2	3	4
27. Feeling Overly Sensitive or Suspicious	0	1	2	3	4
28. Hearing or Seeing Things Other People Don't	0	1	2	3	4
29. Difficulty Trusting People	0	1	2	3	4
30. Memory Problems	0	1	2	3	4

You Use:	**None**	**Infrequent**	**Moderate**	**All the Time**
Caffeine	□	□	□	□
Nicotine	□	□	□	□
Alcohol	□	□	□	□
Marijuana	□	□	□	□
Cocaine	□	□	□	□
Other_____	□	□	□	□