Patient Screening Form

Initial Assessment

SECTION 1: PATIENT INFORMATION

Date: _____

Name: _____ Age: ____ Gender: F M O

Phone number: _____ Community/Village: _____ Region: _____

1. What are the reason/s for which you are seeking help?

a. _____
_____
_____

b. _____
_____
_____

c. _____
_____
_____

2. Please indicate all symptoms that you have experienced within the past two weeks and rank from 1 to 5 how intense these symptoms have been (1 being least intense and 5 being extremely intense):

	1 Least Intense	**2** Somewhat Intense	**3** Moderately Intense	**4** Very Intense	**5** Extremely Intense
Depressed Mood	◯	◯	◯	◯	◯
Racing Thoughts	◯	◯	◯	◯	◯
Excessive Worry	◯	◯	◯	◯	◯
Unable to enjoy activities	◯	◯	◯	◯	◯
Impulsivity	◯	◯	◯	◯	◯
Anxiety Attacks	◯	◯	◯	◯	◯
Sleep Pattern Disturbance	◯	◯	◯	◯	◯
Decreased need for sleep	◯	◯	◯	◯	◯
Increased Risky Behaviour	◯	◯	◯	◯	◯
Loss of Interest	◯	◯	◯	◯	◯
Increased libido	◯	◯	◯	◯	◯
Decreased libido	◯	◯	◯	◯	◯
Hallucinations	◯	◯	◯	◯	◯
Avoidance	◯	◯	◯	◯	◯
Concentration Problems	◯	◯	◯	◯	◯
Decreased need for sleep	◯	◯	◯	◯	◯
Forgetfulness	◯	◯	◯	◯	◯
Suspiciousness	◯	◯	◯	◯	◯
Change in appetite	◯	◯	◯	◯	◯
Excessive energy	◯	◯	◯	◯	◯
Feelings of guilt	◯	◯	◯	◯	◯
Increased irritability	◯	◯	◯	◯	◯

	1 Least Intense	2 Somewhat Intense	3 Moderately Intense	4 Very Intense	5 Extremely Intense
Fatigue	◯	◯	◯	◯	◯
Crying spells	◯	◯	◯	◯	◯

3. On a scale of 1 to 5 (1 being very poor and 5 being the best) How would you rate your current mental health?

1 Very Poor	2 Poor	3 Neither Poor nor Good	4 Good	5 Very Good
◯	◯	◯	◯	◯

4. On a scale of 1 to 5 (1 being very unsatisfied and 5 being highly satisfied) how satisfied are you with life with life in general?

1 Very Unsatisfied	2 Unsatisfied	3 Neither Satisfied nor Unsatisfied	4 Satisfied	5 Highly Satisfied
◯	◯	◯	◯	◯

5. Have you ever had feelings or thoughts that you did not want to live? ◯ Yes ◯ No

*If **YES**, please proceed to the next section. If **NO**, please skip to the next section.*

SECTION 1 Follow Up Questions – if NO answered previously, skip

a. Do you currently feel like you don't want to live? ◯ Yes ◯ No

b. On a scale of 1 to 5 (1 being less frequent and 5 being always), how often do you have these thoughts?

1 Less Frequent	2 Somewhat Frequent	3 Moderately Frequent	4 Often	5 Always
◯	◯	◯	◯	◯

c. When was the last time you had thoughts of dying?

_____

d. Has anything happened recently to make you feel this way?

_____

e. Have you had recent thoughts of suicide? If yes, do you have a plan? (Please explain)

_____

f. Is there anything that would stop you from killing/harming yourself?

_____

g. Do you feel hopeless and/or worthless?

_____

h. Have you ever tried to kill or harm yourself before?

_____

6. Have you ever received mental health services from this or any other public facility before?

◯ Yes ◯ No

If answered **YES,** please specify the name of other public facility: _____

SECTION 2: Health Care Official Information

Name:
Designation:
Facility (at time of Intervention):
Notes and Recommendations:

Signature: _____

Follow-Up Assessment

SECTION 1: PATIENT INFORMATION

Date: _____

Name: _____ Age: ____ Gender: F M O

Phone number: _____ Community/Village: _____ Region: _____

1. Since your initial visit, have you developed any new complaints?

_____
_____
_____

2. Please indicate all symptoms that you have experienced within the past two weeks and rank from 1 to 5 how intense these symptoms have been (1 being least intense and 5 being extremely intense):

	1 Least Intense	**2** Somewhat Intense	**3** Moderately Intense	**4** Very Intense	**5** Extremely Intense
Depressed Mood	◯	◯	◯	◯	◯
Racing Thoughts	◯	◯	◯	◯	◯
Excessive Worry	◯	◯	◯	◯	◯
Unable to enjoy activities	◯	◯	◯	◯	◯
Impulsivity	◯	◯	◯	◯	◯
Anxiety Attacks	◯	◯	◯	◯	◯
Sleep Pattern Disturbance	◯	◯	◯	◯	◯
Decreased need for sleep	◯	◯	◯	◯	◯
Increased Risky Behaviour	◯	◯	◯	◯	◯
Loss of Interest	◯	◯	◯	◯	◯
Increased libido	◯	◯	◯	◯	◯
Decreased libido	◯	◯	◯	◯	◯
Hallucinations	◯	◯	◯	◯	◯
Avoidance	◯	◯	◯	◯	◯
Concentration Problems	◯	◯	◯	◯	◯
Decreased need for sleep	◯	◯	◯	◯	◯
Forgetfulness	◯	◯	◯	◯	◯
Suspiciousness	◯	◯	◯	◯	◯
Change in appetite	◯	◯	◯	◯	◯
Excessive energy	◯	◯	◯	◯	◯
Feelings of guilt	◯	◯	◯	◯	◯
Increased irritability	◯	◯	◯	◯	◯
Fatigue	◯	◯	◯	◯	◯
Crying spells	◯	◯	◯	◯	◯

3. On a scale of 1 to 5 (1 being very poor and 5 being the best) How would you rate your current mental health?

1	2	3	4	5
Very Poor	Poor	Neither Poor nor Good	Good	Very Good
◯	◯	◯	◯	◯

4. On a scale of 1 to 5 (1 being very unsatisfied and 5 being highly satisfied) how satisfied are you with life with life in general?

1	2	3	4	5
Very Unsatisfied	Unsatisfied	Neither Satisfied nor Unsatisfied	Satisfied	Highly Satisfied
◯	◯	◯	◯	◯

5. Have you ever had feelings or thoughts that you did not want to live? ◯ Yes ◯ No.
*If **YES**, please proceed to the next section. If **NO**, please skip to the next section.*

SECTION 1 Follow Up Questions – if NO answered previously, skip

a. Do you currently feel that you don't want to live? ◯ Yes ◯ No
b. On a scale of 1 to 5 (1 being less frequent and 5 being always), how often do you have these thoughts?

1	2	3	4	5
Less Frequent	Somewhat Frequent	Moderately Frequent	Often	Always
◯	◯	◯	◯	◯

c. When was the last time you had thoughts of dying?

_____

d. Has anything happened recently to make you feel this way?

_____

e. Have you had recent thoughts of suicide? If yes, do you have a plan? (Please explain)

_____

f. Is there anything that would stop you from killing/harming yourself?

_____

g. Do you feel hopeless and/or worthless?

_____

h. Have you ever tried to kill or harm yourself before?

_____

SECTION 2: Health Care Official Information

Name:
Designation:
Facility (at time of Intervention):
Notes and Recommendations:

Signature: _____