Name: ______________________________ **Birth date:** ____________ **Today's Date:** ____________

Traverse Health Clinic
Behavioral Health Initial Screening

	Yes	No	
1			Have you had persistent difficulties coping with daily stresses?
2			Have you been feeling sad, blue, down, hopeless, or depressed?
3			Have you had excessive anxiety, tension, worry, fears, or nervousness?
4			Do you have nightmares or flashbacks as a result of being involved in some traumatic or terrible event?
5			Are you having frequent challenges with attention, concentration, impulsiveness, or overactivity?
6			Have you had ongoing challenges with substance use (e.g., alcohol, illicit drugs, prescription medications)?
7			Have you been getting into frequent arguments or been aggressive with others?
8			Do you have frequently fluctuating moods or mood swings?
9			Are you having current thoughts that you would be better off dead or of hurting yourself in some way?
10			Do things feel different than normal, such as strange, unfamiliar, unreal, or detached?
11			Are you hearing noises, sounds, or voices that other people do not hear, or see things others do not see?
12			Do you have challenges with personality, identity, adjustment, or other issues that repeatedly interfere with your daily life?
13			In the past year, have you been seen in an emergency room or hospitalized for a psychological, psychiatric, or emotional problem?
14			Would you like to meet individually with a counselor at Traverse Health Clinic to discuss any of these concerns or issues?

_____ ***Please check this box if the patient declined to complete this form.***

Reviewed: 3/16/16