BIEN ÊTRE PSYCHIATRY

Adult Screening Form

Name: _____

Date of Birth: _____Date: _____

Over the Past 2 Weeks, How Often Have You Experienced the Following?

0 = Never | 1 = Occasionally | 2 = Several Days | 3 = Most Days | 4 = Nearly Every Day

Symptom	0	1	2	3	4
Feeling sad, depressed, or hopeless	☐	☐	☐	☐	☐
Loss of interest or pleasure in activities	☐	☐	☐	☐	☐
Feeling anxious, nervous, or overwhelmed	☐	☐	☐	☐	☐
Panic attacks or intense fear	☐	☐	☐	☐	☐
Excessive worry or overthinking	☐	☐	☐	☐	☐
Irritability, anger, or frustration	☐	☐	☐	☐	☐
Difficulty concentrating or focusing	☐	☐	☐	☐	☐
Problems with memory or forgetfulness	☐	☐	☐	☐	☐
Difficulty falling or staying asleep	☐	☐	☐	☐	☐
Sleeping too much	☐	☐	☐	☐	☐
Low energy or fatigue	☐	☐	☐	☐	☐
Increased energy, racing thoughts, or impulsive behavior	☐	☐	☐	☐	☐
Repetitive thoughts, worries, or mental rituals	☐	☐	☐	☐	☐
Repetitive behaviors or checking habits	☐	☐	☐	☐	☐
Feeling detached, unreal, or disconnected	☐	☐	☐	☐	☐
Hearing or seeing things others do not	☐	☐	☐	☐	☐
Thoughts of self-harm or suicide	☐	☐	☐	☐	☐
Alcohol, marijuana, nicotine, or other substance use causing concern	☐	☐	☐	☐	☐