Creating Connections Counseling Services, LLC

Intake Screening

Please rate from 1 to 10, with **1 being very little** and **10 being very much**, please rate the worst you have experienced the following in the past year; and in your lifetime:

Have you experienced . . .	**Past Year**	**Lifetime**
feeling hyper, having more energy than usual, feeling more self-confident than usual, didn't need as much sleep, had racing thoughts, were more active than usual, more goal-directed activity?		
feeling sad, blue or hopeless?		
loss of interest in things you used to enjoy?		
little energy or motivation to do the things you used to enjoy?		
muscle pain, headaches or stomach aches with no physical cause?		
being restless or on edge, can't stop worrying?		
feeling like your heart was racing, feared you were having a heart attack, felt dizzy or lightheaded, thought you were going crazy or losing control, felt chest pain, pressure or tightness?		
being afraid to go out in public for fear you might be humiliated?		
being bothered by recurrent thoughts, images or impulses that seem inappropriate or don't make sense?		
feeling pressured to do something over and over that you can't resist even when you try?		
being suspicious of others or felt they were out to harm you?		
having difficulty maintaining stable, healthy relationships over a long period of time?		
or witnessed a traumatic or violent event?		
nightmares or flashbacks, or felt numbness?		

Patient Name _____ Patient Signature _____ Date _____