

PERSONAL QUESTIONS - Completed by _____

Do you have **DIFFICULTY** with **DAILY ACTIVITIES**? (Circle YES, describe & explain difficulties)

Cooking full meals Yes / No **If YES**, describe _____

Cleaning Yes / No _____

Grocery Shopping Yes / No _____

Bathing / Dressing Yes / No _____

Laundry Yes / No _____

If you circled **Yes**, who helps you & why do have difficulty? _____

Forget to bathe Yes/No/Need reminder _____

Lack of appetite / lost weight Yes/No _____

Lack of interest in hobbies / activities Yes/No _____

Trouble sleeping / nightmares Yes/No _____

Get tired easily / need rests Yes/No _____

Do not complete this line ADL Limitation: Severe Moderate Slight None

Do you have **DIFFICULTY** with **SOCIAL ACTIVITIES**? EXPLAIN / GIVE EXAMPLES

Don't want to leave house Yes/No **If YES**, describe _____

Don't like crowds/noise Yes/No _____

Trouble dealing with people Yes/No _____

Few / no friends Yes/No _____

Afraid of people Yes/No _____

Irritable / get upset easily Yes/No _____

Get angry easily Yes/No _____

Lack interest in doing things with others Yes/No _____

Do not complete this line Limitation of Social Functioning: Severe Moderate Slight None

DO YOU HAVE DIFFICULTY IN **CONCENTRATION**? EXPLAIN AND GIVE EXAMPLES(**please circle**)

Taking medications / appointments / keys / pay bills / conversations / things others have told you / burn food while cooking / get lost / forget what day it is / need reminders from others / need to make lists.

Can't focus (TV, reading, etc) Yes/No Why? _____

(**Circle**) Anxious / worried / nervous / can't sit still / jumpy / mind races / obsessive thoughts

Easily distracted Yes/No _____

Easily frustrated, no patience Yes/No _____

Disorganized Yes/No _____

Panic attacks Yes/No **If Yes**, how often? _____ / week Describe in detail _____

Trouble handling changes / stress Yes/No _____

Hallucinations / see people or things / hear voices Yes/No

If Yes, describe in detail _____

Do not complete this line Deficiencies in Concentration/Persistence/Pace: Constant Frequent Often Seldom

DO YOU HAVE DIFFICULTY WITH **JOB OR HOME TASKS?** EXPLAIN / GIVE EXAMPLES

Problems starting tasks Yes/No _____

Problems finishing tasks Yes/No _____

Takes longer to do things Yes/No _____

PAST JOB DIFFICULTIES:

(Circle)Trouble dealing with Supervisors / Co-workers / Public?

Explain _____

Missed work days Yes/No Why? _____

Ever fired? Yes/No Why? _____

Ever quit before being fired? Yes/No Explain: _____

Couldn't work fast enough Yes/No Explain _____

Couldn't understand job tasks Yes/No Explain _____

Do not complete this line Deterioration in Work/Work-Like Settings: Continual Repeated Once/Twice Never

DEPRESSION / SADNESS Yes/No Explain _____

THOUGHTS OF SUICIDE Yes/No SUICIDE ATTEMPTS Yes/No If Yes, Dates _____

EVER BEEN HOSPITALIZED FOR PSYCHIATRIC CARE? Yes/No If Yes, Dates: _____

EVER BEEN TREATED IN EMERGENCY ROOM? Yes / No If Yes, Dates: _____

PERIODS OF HOMELESSNESS Yes/No If Yes, when? _____

FEEL HELPLESS / WORTHLESS Yes/No _____

PERSONALITY CHANGES/MOOD SWINGS Yes/No _____

VICTIM OF VIOLENCE Yes/No

VICTIM OF CHILD ABUSE Yes/No **If Yes, circle:** Emotional Physical Sexual

Describe (Optional): _____

HOW MANY **BAD DAYS** DO YOU HAVE IN AN AVERAGE WEEK? 1 2 3 4 5 6 7

DESCRIBE A BAD DAY IN DETAIL: _____

Sign _____

Date _____