

Psychosis / Schizophrenia-Spectrum Symptom & Safety Questionnaire

For hallucinations, delusions, disorganized thinking, severe suspiciousness, negative symptoms, or functional decline.
This form does not diagnose schizophrenia.

Patient name:	_____	Date of birth:	_____
Date completed:	_____	Appointment date:	_____

Urgent review

New psychosis, command hallucinations, severe agitation, catatonia, delirium, intoxication, withdrawal, inability to care for basic needs, or danger to self or others may require urgent or emergency evaluation.

A. Experiences during the past month or currently

During the past month or currently, how often have you experienced the following?

Symptom or experience	Not at all	Several days	More than half	Nearly every day
Hearing voices or sounds that others do not hear	☐	☐	☐	☐
Seeing people, shapes, lights, or images others do not see	☐	☐	☐	☐
Feeling touched, watched, followed, controlled, or monitored without clear evidence	☐	☐	☐	☐
Believing others are trying to harm, poison, deceive, or conspire against you	☐	☐	☐	☐
Believing messages from television, social media, numbers, music, or events are specifically directed at you	☐	☐	☐	☐
Feeling that thoughts are inserted, removed, broadcast, or controlled	☐	☐	☐	☐
Holding a belief that others strongly disagree with and that is difficult to reconsider	☐	☐	☐	☐
Speech that others find hard to follow or that frequently jumps between unrelated topics	☐	☐	☐	☐
Difficulty organizing behavior or completing basic daily tasks	☐	☐	☐	☐

Symptom or experience	Not at all	Several days	More than half	Nearly every day
Markedly reduced speech, motivation, emotional expression, pleasure, or social interest	☐	☐	☐	☐
Staying unusually still, not responding, holding a posture, or showing unusual repetitive movements	☐	☐	☐	☐
Significant decline in work, school, self-care, relationships, or independent living	☐	☐	☐	☐

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B. Details for clinician review

Describe the experience that concerns you most, in your own words:

When did it begin?

Is it continuous or intermittent?

What makes it better or worse?

How convinced are you it is true? 0–100%

Can you ignore or resist it?

Does it affect sleep?

Does it affect eating or self-care?

Does it affect medication adherence?

C. Medical and substance context

Question	No	Yes	Unsure
Did symptoms begin suddenly over hours or days?	☐	☐	☐
Is there fever, infection, head injury, seizure, confusion, disorientation, or major medical illness?	☐	☐	☐
Could alcohol, cannabis, stimulants, hallucinogens, sedatives, opioids, withdrawal, or a new medication be involved?	☐	☐	☐
Have you recently stopped an antipsychotic or missed several doses?	☐	☐	☐
Have you had similar symptoms in the past?	☐	☐	☐

Question	No	Yes	Unsure
Is there a family history of psychosis or bipolar disorder?	☐	☐	☐

D. Immediate safety and ability to care for yourself

Safety question	No	Yes	Unsure
Are voices, visions, beliefs, or impulses telling you to harm yourself or someone else?	☐	☐	☐
Do you believe you must act immediately to protect yourself from a perceived threat?	☐	☐	☐
Do you have access to firearms, weapons, or a large medication supply?	☐	☐	☐
Are you unable to eat, drink, sleep, bathe, dress, obtain shelter, or take essential medication?	☐	☐	☐
Are you driving, wandering, leaving home, spending, or acting in a way others consider dangerous?	☐	☐	☐
Can you stay safe and accept help today?	☐	☐	☐

Support person who may provide collateral information, with permission:

Name / relationship / phone: _____