

# PSYCHIATRIC NURSING INC.

## Patient Resource & Pre-Appointment Workbook

Psychiatric intake questionnaires, symptom check-ins, therapy worksheets, planners, and coping tools

|                  |       |
|------------------|-------|
| Patient name     | <hr/> |
| Date of birth    | <hr/> |
| Appointment date | <hr/> |
| Clinician        | <hr/> |

# A. How to Use This Workbook

## Important safety information

This workbook is not monitored in real time. If you are in immediate danger, unable to stay safe, or believe someone else is in immediate danger, call 911 or go to the nearest emergency department. For suicidal crisis or emotional distress in the United States, call or text 988. Do not use a website form or routine portal message for an emergency.

## Before your appointment

- ☐ Complete the Comprehensive Psychiatric Evaluation Questionnaire for a first appointment or major reassessment.
- ☐ Complete the Medication Management Follow-Up Questionnaire before medication visits.
- ☐ Complete the symptom questionnaire that best matches your current concern. More than one may apply.
- ☐ Bring an updated medication list, pharmacy information, allergies, recent laboratory results, and hospital discharge papers when available.
- ☐ Answer honestly. Your answers help the clinician understand what is happening and do not automatically establish a diagnosis.
- ☐ A clinician may use separate validated screening instruments in addition to these practice-created forms.

## Workbook contents

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### Medication history

| Medication | Dose / schedule | Dates taken | Benefit | Side effects / reason stopped |
|------------|-----------------|-------------|---------|-------------------------------|
|            |                 |             |         |                               |
|            |                 |             |         |                               |
|            |                 |             |         |                               |
|            |                 |             |         |                               |
|            |                 |             |         |                               |
|            |                 |             |         |                               |

Preferred pharmacy and phone number: \_\_\_\_\_

Medication allergies or serious reactions: \_\_\_\_\_

### Alcohol, nicotine, cannabis, and other substances

| Substance                                  | Current use | Typical amount / frequency | Last use | Past problem or treatment? |
|--------------------------------------------|-------------|----------------------------|----------|----------------------------|
| Alcohol                                    |             |                            |          |                            |
| Nicotine / tobacco /<br>vape               |             |                            |          |                            |
| Cannabis / THC / CBD                       |             |                            |          |                            |
| Prescription medication<br>not as directed |             |                            |          |                            |
| Stimulants / cocaine /<br>methamphetamine  |             |                            |          |                            |
| Opioids / fentanyl /<br>heroin             |             |                            |          |                            |
| Sedatives /<br>benzodiazepines             |             |                            |          |                            |

|                       |  |  |  |  |
|-----------------------|--|--|--|--|
| Hallucinogens / other |  |  |  |  |
|-----------------------|--|--|--|--|

### Immediate safety check

#### Answer every item

A “yes” response requires prompt clinical review. If you cannot stay safe, do not wait for a routine appointment.

| Safety question                                                                             | No                       | Yes                      | Unsure                   |
|---------------------------------------------------------------------------------------------|--------------------------|--------------------------|--------------------------|
| Are you having thoughts of suicide or wishing you were dead right now?                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you made a suicide plan, prepared for suicide, or taken steps toward suicide recently? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you having urges to injure yourself?                                                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you having thoughts of harming someone else?                                            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Are voices, visions, beliefs, or impulses telling you to harm yourself or another person?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have access to firearms, large quantities of medication, or another lethal means?    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Can you stay safe until your appointment?                                                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Protective factors, reasons for living, or people you can contact: \_\_\_\_\_

Your three most important treatment goals: \_\_\_\_\_

# Medication Management Follow-Up Questionnaire

Complete before each medication follow-up visit. Bring a current medication list and recent laboratory results when available.

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

## A. Since your last appointment

| Question                                                                                   | No                       | Yes                      | Unsure                   |
|--------------------------------------------------------------------------------------------|--------------------------|--------------------------|--------------------------|
| Did you start, stop, miss, or change any psychiatric medication?                           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Did another clinician start or stop a medication, supplement, or over-the-counter product? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Did you visit an emergency department, urgent care, or hospital?                           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Did you experience a fall, fainting, seizure, pregnancy, major illness, or surgery?        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Did your alcohol, cannabis, nicotine, caffeine, or other substance use change?             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you having trouble obtaining, paying for, or remembering medication?                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Describe the most important change since your last visit:

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## B. Current psychiatric medications

| Medication | Dose | Time taken | Days missed since last visit | Helpful? 0–10 | Side effects or concerns |
|------------|------|------------|------------------------------|---------------|--------------------------|
|            |      |            |                              |               |                          |
|            |      |            |                              |               |                          |
|            |      |            |                              |               |                          |
|            |      |            |                              |               |                          |
|            |      |            |                              |               |                          |
|            |      |            |                              |               |                          |
|            |      |            |                              |               |                          |
|            |      |            |                              |               |                          |

## C. Possible side effects

|                                                                   |                                                                             |
|-------------------------------------------------------------------|-----------------------------------------------------------------------------|
| <input type="checkbox"/> Sleepiness or fatigue                    | <input type="checkbox"/> Insomnia                                           |
| <input type="checkbox"/> Dizziness or fainting                    | <input type="checkbox"/> Restlessness or inability to sit still             |
| <input type="checkbox"/> Tremor, stiffness, or abnormal movements | <input type="checkbox"/> Nausea, constipation, diarrhea, or appetite change |

|                                                               |                                                       |
|---------------------------------------------------------------|-------------------------------------------------------|
| <input type="checkbox"/> Weight change                        | <input type="checkbox"/> Sexual side effects          |
| <input type="checkbox"/> Headache                             | <input type="checkbox"/> Confusion or memory problems |
| <input type="checkbox"/> Rash, swelling, or allergic symptoms | <input type="checkbox"/> Other: _____                 |

Medication Management Follow-Up Questionnaire —

Symptom and function update

| Item                                           | 0 None                                         | 1                        | 2                        | 3                        | 4                        | 5 Severe                 |
|------------------------------------------------|------------------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Depression                                     | <input type="checkbox"/>                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Anxiety                                        | <input type="checkbox"/>                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Irritability / anger                           | <input type="checkbox"/>                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Mood elevation or racing thoughts              | <input type="checkbox"/>                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Concentration / organization problems          | <input type="checkbox"/>                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Hallucinations, paranoia, or unusual beliefs   | <input type="checkbox"/>                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Memory difficulty                              | <input type="checkbox"/>                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Medication side effects                        | <input type="checkbox"/>                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Medication interference with daily life        | <input type="checkbox"/>                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Average hours of sleep per night:<br>_____     | Current appetite / weight change:<br>_____     |                          |                          |                          |                          |                          |
| Current blood pressure, if monitored:<br>_____ | Current pulse, if monitored:<br>_____          |                          |                          |                          |                          |                          |
| Current weight, if monitored:<br>_____         | Last menstrual period, if applicable:<br>_____ |                          |                          |                          |                          |                          |
| Recent laboratory results available?<br>_____  | Pharmacy changed?<br>_____                     |                          |                          |                          |                          |                          |

E. Safety and treatment priorities

| Safety question                                                                               | No                       | Yes                      | Unsure                   |
|-----------------------------------------------------------------------------------------------|--------------------------|--------------------------|--------------------------|
| Since your last visit, have you had thoughts of suicide, self-harm, or wishing you were dead? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Since your last visit, have you had thoughts of harming someone else?                         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have hallucinations, beliefs, or impulses told you to do something dangerous?                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you feel able to stay safe today?                                                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

What is the most important medication question or decision for today?

What medication benefit matters most to you before the next visit?

# Psychotherapy / Talk Therapy Visit Preparation

Use before psychotherapy, supportive therapy, CBT-oriented, trauma-informed, or counseling visits.

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

## A. Current check-in

| Item                              | 0 Lowest                 | 1                        | 2                        | 3                        | 4                        | 5 Highest                |
|-----------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Overall mood                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Anxiety / tension                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Anger / irritability              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Hopefulness                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Energy / motivation               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sleep quality                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Ability to cope                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Connection with supportive people | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

What happened since the last session that feels most important?

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What thoughts, feelings, body sensations, or behaviors have been difficult?

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## B. Therapy focus

|                                                               |                                                                 |
|---------------------------------------------------------------|-----------------------------------------------------------------|
| <input type="checkbox"/> Understand a pattern                 | <input type="checkbox"/> Reduce depression                      |
| <input type="checkbox"/> Manage anxiety or panic              | <input type="checkbox"/> Process grief or loss                  |
| <input type="checkbox"/> Address trauma-related symptoms      | <input type="checkbox"/> Improve relationships or communication |
| <input type="checkbox"/> Set boundaries                       | <input type="checkbox"/> Manage anger or impulsivity            |
| <input type="checkbox"/> Improve sleep                        | <input type="checkbox"/> Improve organization or follow-through |
| <input type="checkbox"/> Prevent relapse                      | <input type="checkbox"/> Make a difficult decision              |
| <input type="checkbox"/> Build self-esteem or self-compassion | <input type="checkbox"/> Other: _____                           |

## Psychotherapy / Talk Therapy Visit Preparation — continued

### C. Skills practice and barriers

| Statement                                                                     | No                       | Yes                      | Not applicable           |
|-------------------------------------------------------------------------------|--------------------------|--------------------------|--------------------------|
| I practiced a skill discussed in therapy.                                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I noticed a recurring thought or behavioral pattern.                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I avoided something important because of fear, low motivation, or discomfort. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I had a conflict or relationship rupture I want to discuss.                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I used alcohol, cannabis, medication, or another substance to cope.           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| I experienced a crisis, self-harm urge, or major safety concern.              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**What skill did you try, and what happened?**

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**What got in the way of progress?**

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### D. Session agenda

**Top priority for this session:**

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**Second priority if time allows:**

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**One action you are willing to take before the next session:**

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### E. Safety check

| Safety question                                                          | No                       | Yes                      | Unsure                   |
|--------------------------------------------------------------------------|--------------------------|--------------------------|--------------------------|
| Are you having thoughts of suicide, self-harm, or wishing you were dead? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you having thoughts of harming another person?                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you feel safe in your current environment?                            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Can you stay safe until your next clinical contact?                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

# ADHD Evaluation & Management Questionnaire

For adult attention, organization, impulsivity, hyperactivity, and executive-function concerns. This form is not a stand-alone ADHD diagnosis.

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

## Diagnostic context

ADHD evaluation requires evidence of persistent symptoms, impairment in more than one setting, developmental history, and consideration of sleep, mood, anxiety, trauma, substance use, learning, medical, and neurologic causes.

## A. Current attention and executive-function symptoms

During the past 6 months, how often have you experienced the following?

| Symptom or experience                                              | Not at all               | Several days             | More than half           | Nearly every day         |
|--------------------------------------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Miss important details or make avoidable mistakes                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Lose focus during reading, conversations, meetings, or tasks       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Seem not to listen even when spoken to directly                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Start tasks but fail to finish them                                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have difficulty organizing tasks, materials, time, or appointments | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Avoid or delay tasks requiring sustained mental effort             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Lose items needed for work or daily life                           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Become distracted by sounds, activity, thoughts, or devices        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Forget appointments, bills, responsibilities, or daily tasks       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Feel physically restless or fidget frequently                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Leave a seat or situation when expected to remain                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Feel internally driven, "on the go," or unable to relax            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Talk excessively or interrupt others                               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Answer before a question is finished                               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have difficulty waiting your turn                                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Act quickly without considering consequences                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

ADHD Evaluation & Management Questionnaire — continued

## B. Developmental and cross-setting history

| Question                                                                      | No                       | Yes                      | Unsure                   |
|-------------------------------------------------------------------------------|--------------------------|--------------------------|--------------------------|
| Were similar symptoms present before age 12, even if they were not diagnosed? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| Question                                                                                                                                          | No                       | Yes                      | Unsure                   |
|---------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|--------------------------|
| Did teachers or caregivers describe distractibility, excessive activity, impulsivity, incomplete work, or behavior concerns?                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Did symptoms affect grades, homework, attendance, friendships, or family life?                                                                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Are symptoms currently present in at least two settings, such as home, work, school, relationships, or community activities?                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Do symptoms cause meaningful impairment rather than only inconvenience?                                                                           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Can symptoms be explained mainly by poor sleep, anxiety, depression, trauma, mania, psychosis, substance use, medication, or a medical condition? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**Examples from childhood or school records:** \_\_\_\_\_

**Examples at work, school, or home now:** \_\_\_\_\_

### C. Executive-function impact

| Item                                | 0 None                   | 1 Mild                   | 2 Moderate               | 3 Severe                 | 4 Extreme                |
|-------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Starting tasks                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Estimating time                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Prioritizing                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Following multi-step instructions   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Managing paperwork, email, or bills | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Regulating emotions                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Stopping distractions               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Remembering future tasks            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Completing tasks accurately         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Maintaining routines                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

### D. Treatment and monitoring

| Question                                                                                                                      | No                       | Yes                      | Unsure                   |
|-------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|--------------------------|
| Have you previously taken stimulant medication?                                                                               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you previously taken non-stimulant ADHD medication?                                                                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you used coaching, CBT, organizational systems, or school/work accommodations?                                           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have heart disease, fainting, uncontrolled blood pressure, seizures, glaucoma, tics, pregnancy, or an eating disorder? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Is there a personal or family history of substance misuse or diversion concerns?                                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Is there a personal or family history of bipolar disorder, psychosis, or sudden cardiac death?                                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**What ADHD-related change would most improve your daily life?**

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# Depression Symptom Questionnaire

Use for depression treatment visits or when low mood, loss of interest, energy, motivation, guilt, or hopelessness are concerns.

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

During the past 2 weeks, how often have you experienced the following? *Select the response that best reflects your experience.*

| Symptom or experience                                                            | Not at all               | Several days             | More than half           | Nearly every day         |
|----------------------------------------------------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Little interest or pleasure in activities                                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Feeling sad, depressed, empty, or hopeless                                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sleep difficulty or sleeping much more than usual                                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Low energy or fatigue                                                            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Poor appetite, overeating, or weight change                                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Feeling worthless, guilty, or like a failure                                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty concentrating, reading, or making decisions                           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Moving or speaking unusually slowly, or feeling unusually restless               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Thoughts that you would be better off dead, suicide thoughts, or self-harm urges | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

How difficult have these symptoms made work, school, home responsibilities, or relationships?

☐ Not difficult   ☐ Somewhat difficult   ☐ Very difficult   ☐ Extremely difficult

What situations, losses, medical issues, medications, or life changes may be contributing?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

| Clinical safety question                                                                          | No                       | Yes                      | Unsure                   |
|---------------------------------------------------------------------------------------------------|--------------------------|--------------------------|--------------------------|
| Have you ever had a period of unusually elevated or irritable mood with much less need for sleep? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had psychotic symptoms, severe confusion, or inability to care for yourself?             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you currently having suicide thoughts, a plan, intent, or recent preparatory behavior?        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Can you stay safe until you are evaluated?                                                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

What has helped, even a little?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# Anxiety Symptom Questionnaire

Use for generalized anxiety, panic, social anxiety, phobias, health anxiety, or stress-related concerns.

|                 |       |                   |       |
|-----------------|-------|-------------------|-------|
| Patient name:   | <hr/> | Date of birth:    | <hr/> |
| Date completed: | <hr/> | Appointment date: | <hr/> |

During the past 2 weeks, how often have you experienced the following?

| Symptom or experience                                                                    | Not at all               | Several days             | More than half           | Nearly every day         |
|------------------------------------------------------------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Feeling nervous, anxious, tense, or on edge                                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty controlling worry                                                             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Worrying about many different things                                                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty relaxing                                                                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Restlessness or feeling keyed up                                                         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Becoming easily irritated                                                                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Fear that something terrible may happen                                                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Panic episodes with sudden intense fear or physical symptoms                             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Avoiding places, people, activities, driving, travel, or appointments because of anxiety | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

How difficult have these symptoms made work, school, home responsibilities, or relationships?

☐ Not difficult   ☐ Somewhat difficult   ☐ Very difficult   ☐ Extremely difficult

## Panic and avoidance details

| Question                                                                                                                                 | No                       | Yes                      | Unsure                   |
|------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|--------------------------|
| Do symptoms peak suddenly within minutes?                                                                                                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Do episodes include chest discomfort, shortness of breath, dizziness, shaking, sweating, nausea, numbness, or fear of losing control?    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you worry about having another episode?                                                                                               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you changed your behavior or avoided situations because of panic?                                                                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have medical causes such as thyroid disease, heart rhythm problems, asthma, medication effects, caffeine, or substances been considered? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Main worries, triggers, or avoided situations:

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What do you do to feel safer or reduce anxiety?

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# PTSD / Trauma-Related Symptom Questionnaire

Complete only if trauma-related symptoms are relevant. You do not need to describe graphic details on this form.

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

## Choice and privacy

You may write only what feels necessary. Tell your clinician if completing this form increases distress or makes you feel unsafe.

Brief description or type of event, if you choose to provide it: \_\_\_\_\_

Approximate age or date: \_\_\_\_\_

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

| Symptom or experience                                                           | Not at all               | Several days             | More than half           | Nearly every day         |
|---------------------------------------------------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Unwanted memories, images, or thoughts about the event                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Disturbing dreams related to the event                                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Feeling or acting as if the event were happening again                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Strong emotional distress when reminded                                         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Physical reactions when reminded                                                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Avoiding memories, thoughts, or feelings related to the event                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Avoiding people, places, conversations, or activities that remind you           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty remembering important parts of the event                             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Persistent negative beliefs about yourself, others, safety, trust, or the world | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Blaming yourself or others in a way that causes distress                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Persistent fear, guilt, shame, anger, or horror                                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Loss of interest or feeling detached from others                                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty experiencing positive emotions                                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Irritability, anger outbursts, or reckless behavior                             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Being overly alert, watchful, or easily startled                                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty concentrating                                                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty falling or staying asleep                                            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

## PTSD / Trauma-Related Symptom Questionnaire

### Current impact and stabilization

| Item                                                               | 0 None                   | 1 Mild                   | 2 Moderate               | 3 Severe                 | 4 Extreme                |
|--------------------------------------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Interference with work or school                                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Interference with relationships                                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Interference with sleep                                            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Interference with leaving home or daily activities                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Use of alcohol, cannabis, medication, or another substance to cope | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Feeling disconnected, unreal, numb, or outside your body           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| Question                                                                                  | No                       | Yes                      | Unsure                   |
|-------------------------------------------------------------------------------------------|--------------------------|--------------------------|--------------------------|
| Are you currently in contact with the person or situation associated with the trauma?     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you currently feel unsafe in your home or relationship?                                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you recently had suicide thoughts, self-harm urges, or dangerous impulsive behavior? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have grounding or coping skills that help you return to the present?               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have at least one supportive person or safe place?                                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

#### Known triggers:

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#### Grounding strategies, supports, or activities that help:

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#### What would help you feel safer during treatment?

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# Bipolar Spectrum / Mood Episode Questionnaire

*For lifetime periods of elevated, expansive, or unusually irritable mood, especially when accompanied by increased energy or reduced need for sleep.*

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

## Important

Normal happiness, brief excitement, medication effects, and substance intoxication are not the same as hypomania or mania. A clinician must evaluate duration, severity, change from baseline, impairment, psychosis, and alternative causes.

## Lifetime elevated or irritable mood symptoms

| Question                                                                                                                   | No                                         | Yes                      | Unsure                   |
|----------------------------------------------------------------------------------------------------------------------------|--------------------------------------------|--------------------------|--------------------------|
| Have you had a distinct period when your mood was unusually elevated, expansive, or irritable compared to your usual self? | <input type="checkbox"/>                   | <input type="checkbox"/> | <input type="checkbox"/> |
| During that period, did you need much less sleep and still feel rested?                                                    | <input type="checkbox"/>                   | <input type="checkbox"/> | <input type="checkbox"/> |
| Did you talk more or faster than usual, or feel pressure to keep talking?                                                  | <input type="checkbox"/>                   | <input type="checkbox"/> | <input type="checkbox"/> |
| Did your thoughts race or jump rapidly from topic to topic?                                                                | <input type="checkbox"/>                   | <input type="checkbox"/> | <input type="checkbox"/> |
| Were you more distractible than usual?                                                                                     | <input type="checkbox"/>                   | <input type="checkbox"/> | <input type="checkbox"/> |
| Did you have increased energy, activity, productivity, socializing, sexuality, or goal-directed behavior?                  | <input type="checkbox"/>                   | <input type="checkbox"/> | <input type="checkbox"/> |
| Did you feel unusually confident, powerful, talented, important, or invulnerable?                                          | <input type="checkbox"/>                   | <input type="checkbox"/> | <input type="checkbox"/> |
| Did you spend excessively, drive recklessly, gamble, use substances, become sexually impulsive, or take unusual risks?     | <input type="checkbox"/>                   | <input type="checkbox"/> | <input type="checkbox"/> |
| Did others notice a clear change in you?                                                                                   | <input type="checkbox"/>                   | <input type="checkbox"/> | <input type="checkbox"/> |
| Did the episode cause major impairment, hospitalization, legal problems, relationship damage, or psychosis?                | <input type="checkbox"/>                   | <input type="checkbox"/> | <input type="checkbox"/> |
| Longest episode duration:<br>_____                                                                                         | Approximate age at first episode:<br>_____ |                          |                          |
| Most recent episode date:<br>_____                                                                                         | Number of similar episodes:<br>_____       |                          |                          |
| Total hours of sleep during episode:<br>_____                                                                              | Hospitalization required?<br>_____         |                          |                          |
| Substance or medication involved?<br>_____                                                                                 | Psychotic symptoms present?<br>_____       |                          |                          |

### Depressive episodes and pattern

| Question                                                                                                             | No                       | Yes                      | Unsure                   |
|----------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|--------------------------|
| Have you had a period of at least two weeks with depressed mood or loss of interest plus other depressive symptoms?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Do mood episodes occur after childbirth, seasonal changes, antidepressant treatment, sleep loss, or substance use?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Has an antidepressant ever caused marked agitation, insomnia, racing thoughts, impulsivity, or elevated mood?        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Is there a biological family history of bipolar disorder, hospitalization for mood episodes, or suicide?             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Have episodes caused job loss, financial damage, relationship disruption, arrest, or inability to care for yourself? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**Describe the clearest elevated or irritable episode:**

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**Describe the clearest depressive episode:**

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### C. Current episode and safety

| Current safety question                                                                      | No                       | Yes                      | Unsure                   |
|----------------------------------------------------------------------------------------------|--------------------------|--------------------------|--------------------------|
| Are you currently sleeping much less than usual without feeling tired?                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you currently unusually impulsive, agitated, aggressive, or unable to slow down?         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you currently hearing voices, seeing things, or holding beliefs others say are not true? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you having suicide thoughts, self-harm urges, or thoughts of harming someone else?       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Can you safely manage medications, money, driving, work, and caregiving today?               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

# 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                                                             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Seeing people, shapes, lights, or images others do not see                                                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Feeling touched, watched, followed, controlled, or monitored without clear evidence                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Believing others are trying to harm, poison, deceive, or conspire against you                                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Believing messages from television, social media, numbers, music, or events are specifically directed at you | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Feeling that thoughts are inserted, removed, broadcast, or controlled                                        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Holding a belief that others strongly disagree with and that is difficult to reconsider                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Speech that others find hard to follow or that frequently jumps between unrelated topics                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty organizing behavior or completing basic daily tasks                                               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Markedly reduced speech, motivation, emotional expression, pleasure, or social interest                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Staying unusually still, not responding, holding a posture, or showing unusual repetitive movements          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Significant decline in work, school, self-care, relationships, or independent living                         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Psychosis / Schizophrenia-Spectrum Symptom & Safety Questionnaire — continued

## B. Details for clinician review

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

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|                                              |                                                   |
|----------------------------------------------|---------------------------------------------------|
| When did it begin?<br>_____                  | Is it continuous or intermittent?<br>_____        |
| What makes it better or worse?<br>_____      | How convinced are you it is true? 0–100%<br>_____ |
| Can you ignore or resist it?<br>_____        | Does it affect sleep?<br>_____                    |
| Does it affect eating or self-care?<br>_____ | Does it affect medication adherence?<br>_____     |

#### 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?           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you believe you must act immediately to protect yourself from a perceived threat?              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have access to firearms, weapons, or a large medication supply?                            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you unable to eat, drink, sleep, bathe, dress, obtain shelter, or take essential medication?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you driving, wandering, leaving home, spending, or acting in a way others consider dangerous? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Can you stay safe and accept help today?                                                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Support person who may provide collateral information, with permission: \_\_\_\_\_

Name / relationship / phone: \_\_\_\_\_

# Cognitive Restructuring Worksheet

A CBT thought record for identifying automatic thoughts, examining evidence, and developing a more balanced response.

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

## Use this worksheet

Choose one specific situation. The goal is not forced positivity; it is a more accurate, useful, and compassionate perspective.

### Step 1. Situation or trigger

What happened? Include the time, place, people involved, and observable facts.

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### Step 2. Emotions and body sensations

| Emotion / sensation | Intensity before (0–100) | Where felt in the body |
|---------------------|--------------------------|------------------------|
|                     |                          |                        |
|                     |                          |                        |
|                     |                          |                        |
|                     |                          |                        |
|                     |                          |                        |

### Step 3. Automatic thought or image

What went through your mind? What did this situation seem to mean about you, others, or the future?

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How strongly did you believe the thought? 0–100%: \_\_\_\_\_

### Step 4. Possible thinking patterns

☐ All-or-nothing thinking ☐ Overgeneralizing ☐ Mental filter ☐ Discounting positives ☐ Jumping to conclusions ☐ Mind reading ☐ Fortune telling ☐ Catastrophizing ☐ Emotional reasoning ☐ “Should” statements ☐ Labeling ☐ Personalization ☐ Blaming ☐ Unfair comparison

## Cognitive Restructuring Worksheet — continued

### Step 5. Examine the evidence

| Evidence supporting the thought | Evidence that does not support the thought / alternative information |
|---------------------------------|----------------------------------------------------------------------|
|                                 |                                                                      |
|                                 |                                                                      |
|                                 |                                                                      |
|                                 |                                                                      |
|                                 |                                                                      |
|                                 |                                                                      |
|                                 |                                                                      |

### Step 6. Balanced alternative thought

Write a response that acknowledges the difficulty and includes the full evidence. What would you say to someone you care about?

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How strongly do you believe the original thought now? 0–100%: \_\_\_\_\_

Emotion intensity now? 0–100%: \_\_\_\_\_

### Step 7. Helpful next action

What is one realistic, values-consistent action you can take next?

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# 5-4-3-2-1 Grounding Method Guide

*A present-moment sensory exercise for anxiety, panic, trauma reminders, dissociation, or emotional overload.*

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

## Pause first

Place both feet on a stable surface if possible. Breathe naturally. Look around and remind yourself: "I am here, in the present, and I am noticing my surroundings."

### 5 things you can SEE

Name colors, shapes, light, objects, or movement.

\_\_\_\_\_  
\_\_\_\_\_

### 4 things you can FEEL

Notice your feet, clothing, chair, temperature, or an object in your hand.

\_\_\_\_\_  
\_\_\_\_\_

### 3 things you can HEAR

Notice nearby and distant sounds without judging them.

\_\_\_\_\_  
\_\_\_\_\_

### 2 things you can SMELL

Notice scents in the room, outdoors, or on an item. If none are present, recall two familiar scents.

\_\_\_\_\_  
\_\_\_\_\_

### 1 thing you can TASTE

Notice your current taste or take a safe sip of water, mint, or gum.

\_\_\_\_\_  
\_\_\_\_\_

## After grounding

Distress before (0–10): \_\_\_\_\_

Distress after (0–10): \_\_\_\_\_

What helped most? \_\_\_\_\_

## If symptoms increase

Stop the exercise, orient to a safe person or place, and use a different coping strategy. Seek urgent help if you cannot stay safe.

# ADHD Task Prioritizer & Weekly Planner

*Use to reduce overwhelm, identify the next visible action, estimate time, and protect focused work periods.*

|                        |       |                          |       |
|------------------------|-------|--------------------------|-------|
| <b>Patient name:</b>   | _____ | <b>Date of birth:</b>    | _____ |
| <b>Date completed:</b> | _____ | <b>Appointment date:</b> | _____ |

## A. Brain dump

**Write every task, obligation, idea, worry, or reminder currently taking up mental space:**

[illegible]

### B. Sort by urgency and importance

[illegible]



## ADHD Task Prioritizer & Weekly Planner — continued

### C. Choose this week's priorities

| Priority | Outcome / definition of done | First visible action | Estimated time | Deadline | Support / reward |
|----------|------------------------------|----------------------|----------------|----------|------------------|
| 1        |                              |                      |                |          |                  |
| 2        |                              |                      |                |          |                  |
| 3        |                              |                      |                |          |                  |
| 4        |                              |                      |                |          |                  |
| 5        |                              |                      |                |          |                  |

### D. Task breakdown

Task to break down: \_\_\_\_\_

| Step | Action small enough to start | Time needed | Done                     |
|------|------------------------------|-------------|--------------------------|
| 1    |                              |             | <input type="checkbox"/> |
| 2    |                              |             | <input type="checkbox"/> |
| 3    |                              |             | <input type="checkbox"/> |
| 4    |                              |             | <input type="checkbox"/> |
| 5    |                              |             | <input type="checkbox"/> |
| 6    |                              |             | <input type="checkbox"/> |
| 7    |                              |             | <input type="checkbox"/> |
| 8    |                              |             | <input type="checkbox"/> |

## ADHD Task Prioritizer & Weekly Planner — continued

### E. Weekly plan

| Day       | Top 1–3 priorities | Appointments / fixed commitments | Focus block | Reset / self-care |
|-----------|--------------------|----------------------------------|-------------|-------------------|
| Monday    |                    |                                  |             |                   |
| Tuesday   |                    |                                  |             |                   |
| Wednesday |                    |                                  |             |                   |
| Thursday  |                    |                                  |             |                   |
| Friday    |                    |                                  |             |                   |
| Saturday  |                    |                                  |             |                   |
| Sunday    |                    |                                  |             |                   |

### F. Distraction plan

|                                                  |                                           |
|--------------------------------------------------|-------------------------------------------|
| Likely distraction:<br>_____                     | How I will reduce it:<br>_____            |
| Task I tend to avoid:<br>_____                   | Two-minute starting step:<br>_____        |
| Person who can body-double or check in:<br>_____ | Reward after completion:<br>_____         |
| Where I will park new ideas:<br>_____            | Time to review unfinished tasks:<br>_____ |

# 13. Sleep Hygiene Checklist & 7-Day Sleep Log

Use for insomnia, irregular sleep, daytime fatigue, mood instability, medication monitoring, or ADHD management.

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

## A. Sleep hygiene checklist

|                                                                                                                                        |                                                                                                                                                |
|----------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> I keep a consistent wake time, including weekends when possible.                                              | <input type="checkbox"/> I use the bed primarily for sleep and intimacy rather than work, scrolling, or prolonged worry.                       |
| <input type="checkbox"/> I create a 30–60 minute wind-down period.                                                                     | <input type="checkbox"/> I reduce bright light and stimulating screens before bed.                                                             |
| <input type="checkbox"/> I avoid caffeine late in the day and track how long it affects me.                                            | <input type="checkbox"/> I avoid nicotine, alcohol, cannabis, and heavy meals close to bedtime.                                                |
| <input type="checkbox"/> I exercise regularly but avoid vigorous exercise immediately before bed if it is activating.                  | <input type="checkbox"/> I keep the bedroom dark, quiet, comfortable, and cool enough for sleep.                                               |
| <input type="checkbox"/> If unable to sleep for a prolonged period, I leave bed for a quiet low-light activity and return when sleepy. | <input type="checkbox"/> I avoid clock-watching.                                                                                               |
| <input type="checkbox"/> I limit naps or keep them earlier and brief when naps worsen nighttime sleep.                                 | <input type="checkbox"/> I take medications as directed and discuss stimulating or sedating effects with my clinician.                         |
| <input type="checkbox"/> I use a consistent method to write down worries or next-day tasks before bed.                                 | <input type="checkbox"/> I seek evaluation for loud snoring, gasping, restless legs, sleepwalking, severe nightmares, or dangerous sleepiness. |

## B. Sleep concerns

| Question                                      | No                       | Yes                      | Unsure                   |
|-----------------------------------------------|--------------------------|--------------------------|--------------------------|
| Difficulty falling asleep                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Frequent awakenings                           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Waking too early                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sleeping too much                             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Nightmares                                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Loud snoring or gasping                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Restless legs or unusual movements            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sleepwalking or acting out dreams             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Unplanned daytime sleep episodes              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Driving or work safety affected by sleepiness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

## Sleep Hygiene Checklist & 7-Day Sleep Log — continued

## C. Seven-day sleep log — timing

| Day / date | Got into bed | Lights out | Approx. minutes to fall asleep | Number / total time awake | Final wake time | Out of bed | Estimated total sleep |
|------------|--------------|------------|--------------------------------|---------------------------|-----------------|------------|-----------------------|
| 1          |              |            |                                |                           |                 |            |                       |

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 2 |  |  |  |  |  |  |  |
| 3 |  |  |  |  |  |  |  |
| 4 |  |  |  |  |  |  |  |
| 5 |  |  |  |  |  |  |  |
| 6 |  |  |  |  |  |  |  |
| 7 |  |  |  |  |  |  |  |

Usual sleep schedule before the current problem: \_\_\_\_\_

Desired sleep and wake times: \_\_\_\_\_

### Sleep Hygiene Checklist & 7-Day Sleep Log — continued

#### D. Seven-day sleep log — factors affecting sleep

| Day | Nap(s): time / length | Caffeine: type / time | Alcohol / cannabis / nicotine | Exercise: type / time | Sleep medication / time | Sleep quality 0–10 | Daytime sleepiness 0–10 |
|-----|-----------------------|-----------------------|-------------------------------|-----------------------|-------------------------|--------------------|-------------------------|
| 1   |                       |                       |                               |                       |                         |                    |                         |
| 2   |                       |                       |                               |                       |                         |                    |                         |
| 3   |                       |                       |                               |                       |                         |                    |                         |
| 4   |                       |                       |                               |                       |                         |                    |                         |
| 5   |                       |                       |                               |                       |                         |                    |                         |
| 6   |                       |                       |                               |                       |                         |                    |                         |
| 7   |                       |                       |                               |                       |                         |                    |                         |

#### E. Patterns noticed

What seems to improve sleep?

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What seems to worsen sleep?

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Questions for your clinician:

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## 14. Box Breathing Technique Card

*A brief paced-breathing practice that may help lower physiologic arousal and create a pause before responding.*

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

### Before starting

Sit or stand safely. Loosen your shoulders and jaw. Breathe gently rather than taking very large breaths. Stop if you become dizzy, faint, more panicked, or physically uncomfortable. People with significant breathing or cardiac conditions should follow clinician guidance.

|   |        |                   |          |
|---|--------|-------------------|----------|
| 1 | INHALE | through the nose  | 4 counts |
| 2 | HOLD   | without straining | 4 counts |
| 3 | EXHALE | slowly and gently | 4 counts |
| 4 | HOLD   | at the bottom     | 4 counts |

### Practice

- ☐ Complete 4 cycles.
- ☐ Return to normal breathing for 30–60 seconds.
- ☐ Repeat only if comfortable.
- ☐ Pair with a cue: “Slow down,” “I can pause,” or “One step at a time.”

|                                         |                                     |
|-----------------------------------------|-------------------------------------|
| Distress before, 0–10:<br>_____         | Distress after, 0–10:<br>_____      |
| Number of cycles completed:<br>_____    | What changed in your body?<br>_____ |
| Where will you use this skill?<br>_____ | Reminder cue or phrase:<br>_____    |

# 15. Mood, Symptom & Medication Tracker

Use between appointments to identify patterns in mood, sleep, anxiety, medication adherence, side effects, and daily functioning.

|                 |             |                   |             |
|-----------------|-------------|-------------------|-------------|
| Patient name:   | <div></div> | Date of birth:    | <div></div> |
| Date completed: | <div></div> | Appointment date: | <div></div> |

| Date | Mood 0–10 | Anxiety 0–10 | Energy 0–10 | Sleep hours / quality | Medication taken as prescribed? | Side effects | Important events / notes |
|------|-----------|--------------|-------------|-----------------------|---------------------------------|--------------|--------------------------|
|      |           |              |             |                       |                                 |              |                          |
|      |           |              |             |                       |                                 |              |                          |
|      |           |              |             |                       |                                 |              |                          |
|      |           |              |             |                       |                                 |              |                          |
|      |           |              |             |                       |                                 |              |                          |
|      |           |              |             |                       |                                 |              |                          |
|      |           |              |             |                       |                                 |              |                          |
|      |           |              |             |                       |                                 |              |                          |
|      |           |              |             |                       |                                 |              |                          |
|      |           |              |             |                       |                                 |              |                          |
|      |           |              |             |                       |                                 |              |                          |
|      |           |              |             |                       |                                 |              |                          |
|      |           |              |             |                       |                                 |              |                          |
|      |           |              |             |                       |                                 |              |                          |
|      |           |              |             |                       |                                 |              |                          |
|      |           |              |             |                       |                                 |              |                          |
|      |           |              |             |                       |                                 |              |                          |

## Rating guide

0 may represent the lowest or least intense level, and 10 the highest or most intense level. Use the same meaning

each day  
so  
patterns  
are  
easier to  
interpret.

Mood, Symptom & Medication Tracker — continued

Weekly review

Best day this week and possible reasons:

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Most difficult day this week and possible reasons:

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Medication benefits noticed:

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Side effects or adherence barriers:

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Patterns involving sleep, caffeine, alcohol/cannabis, menstrual cycle, stress, or activity:

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Important questions for the next appointment:

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# 16. Appointment Readiness Checklist

Use before in-person or telepsychiatry appointments.

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

## Documents and information

- ☐ Completed requested questionnaires or symptom trackers
- ☐ Current medication list, including vitamins, supplements, and over-the-counter products
- ☐ Medication bottles or photos of labels when the list is uncertain
- ☐ Allergy and adverse-reaction list
- ☐ Preferred pharmacy name, location, and phone number
- ☐ Recent laboratory results, vital signs, weight, ECG, imaging, or discharge paperwork if relevant
- ☐ Insurance card and identification, when required
- ☐ Names and contact information for primary care and other treating clinicians
- ☐ Questions, treatment priorities, and medication refill needs
- ☐ Information about pregnancy, breastfeeding, contraception, or pregnancy plans when relevant
- ☐ A support person available for collateral information, when appropriate and authorized

## Telepsychiatry setup

- ☐ Private, reasonably quiet location
- ☐ Charged device and stable internet connection
- ☐ Camera and microphone tested
- ☐ Headphones available if privacy is limited
- ☐ Physical location and emergency contact available to provide at the start of the visit
- ☐ Medication list and pharmacy information within reach
- ☐ No driving or operating machinery during the appointment
- ☐ Plan for childcare, pets, interruptions, and translation needs

## Top questions for today

1.  
\_\_\_\_\_  
\_\_\_\_\_
2.  
\_\_\_\_\_  
\_\_\_\_\_
3.  
\_\_\_\_\_  
\_\_\_\_\_
4.  
\_\_\_\_\_  
\_\_\_\_\_
5.  
\_\_\_\_\_  
\_\_\_\_\_

Emergency reminder

Routine appointments, email, voicemail, and portal messages are not emergency services. Call 911 or go to the nearest emergency department for immediate danger. In the United States, call or text 988 for suicidal crisis or emotional distress.

## R. Clinical Reference & Customization Notes

*For practice use and document governance.*

### Clinical framework

- American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR). Washington, DC: American Psychiatric Association Publishing; 2022.
- National Institute of Mental Health. Help for Mental Illnesses and mental health education resources.
- 988 Suicide & Crisis Lifeline. U.S. crisis support information.
- The questionnaires in this workbook are original practice-created clinical intake and monitoring forms. They are not substitutes for copyrighted or validated instruments and should not be represented as PHQ-9, GAD-7, ASRS, PCL-5, MDQ, PANSS, or other named scales.
- Clinicians should adapt forms to patient age, developmental level, literacy, language, disability access needs, scope of practice, informed-consent requirements, privacy practices, and applicable federal and state law.

### Practice customization fields

|                                        |                                          |
|----------------------------------------|------------------------------------------|
| Practice phone:<br>_____               | Practice fax:<br>_____                   |
| Practice email:<br>_____               | Patient portal:<br>_____                 |
| Business hours:<br>_____               | After-hours instructions:<br>_____       |
| Nearest emergency department:<br>_____ | Local crisis / mobile response:<br>_____ |
| Document owner:<br>_____               | Review date / version:<br>_____          |

Additional practice-specific instructions:

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