

Date: \_\_\_\_\_ Name: \_\_\_\_\_

**Return visit questionnaire - please complete prior to EACH visit** *Please visit*

[www.vakkur.com/qa\\_rtn.htm](http://www.vakkur.com/qa_rtn.htm) for future/additional forms.

Please check the appropriate box to rate yourself for the following symptoms over the **past 2 weeks**, using the following Rating Scale:  
**0 = not present; 1 = present only rarely; 2 = present most days; 3 = severe or present almost every day.**

Symptom:	Rating 0-3:	Circle any of the following you may have experienced in the past 2 weeks:
1. Decreased <b>interest</b> , inability to enjoy things:		
2. Depressed or anxious <b>mood</b> :		crying spells    panic attacks    rumination and worry    obsessions
3. Decreased or increased <b>sleep</b> (circle which):		<i>If sleep is a problem:</i> difficulty <b>falling</b> asleep    difficulty <b>staying</b> asleep time I usually <b>go to bed</b> : ____;    time I <b>fall asleep</b> : ____;    time I <b>wake up</b> : ____. Total hours of sleep in 24 hour period (including naps): _____.
4. Decreased or increased <b>energy</b> :		feeling tired much of the time    feeling unmotivated feeling "revved up"    nervous energy
5. Decreased or increased <b>appetite</b> :		binge eating    purging    calorie restriction    fasting    frequent weighing use of laxatives to lose weight    obsessing about food or weight
6. <b>Guilt feelings</b> or feelings of worthlessness or <b>failure</b> :		feeling of failure    feeling of inadequacy feeling I did something very bad (even if I didn't)
7. Decreased <b>concentration</b> or memory:		difficulty focusing    difficulty staying focused    distractibility    problems with organization    difficulty remembering things
8. Feeling either slowed down or agitated:		feeling sluggish, like moving through molasses feeling "wired" with too much energy    feeling snappy    feeling irritable    arguing more anger outbursts    rage attacks
9. <b>Suicidal thoughts</b> , or thoughts that you would be better off dead:		thoughts I would be better off dead    plans to harm myself intent to harm myself    intent to harm someone else
10. Decreased libido:		low desire    low response
11. Use of <b>alcohol</b> :		average daily alcohol use: ____;    maximum: ____.
12. <b>Substance use</b> other than alcohol:		

On a scale of 0-10, where 10 is the most and 0 is none, please rate the following over the past 2 weeks:

13. Your feelings of <b>DEPRESSION</b> or <b>SADNESS</b> (0-10):	
14. Your feelings of <b>ANXIETY</b> (0-10):	

15. If you are on **medications**, please complete the following *reflecting what you are actually taking*:

Medication name:	Dose:	Frequency:	Is it helping? +++ = very much so; + = maybe a little, 0 = not at all	Any side effects?
<i>Example: Lexapro</i>	<i>10 mg</i>	<i>Once a day</i>	<i>++</i>	<i>Mild sedation</i>