**Today’s Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications from psychiatrist please indicate:

Medications from primary care/other specialist:

Side effects to medications listed above:

Over the counter medications:

I Take My Medications: **precisely/ fairly regularly/on and off/ stopped/when: \_\_\_\_**

PLEASE REPORT:

MOOD**:** **stable/ ok/ fairly good/ good/ high/ anxious/ depressed/ up and down**

SLEEP: **good/ interrupted/ insomnia/ sleep only with medication/ snore**

**How many hours of sleep a day? \_\_\_\_**

CONCENTRATION: **good/distracted/ fast thoughts/ excessive worrying/ obsessing**

CUTTING: **Yes/No Daily/ Weekly**

ENERGY LEVEL: **good/ energetic/ high/ high strung/ restless/ tense/ agitated/ fatigued/ taking naps/** **tired in the morning/ nod off during the day**

DOING OVERALL: **improved/ same as previously/ slightly worsened/ totally relapsed**

APPETITE: **good/ fairly good/ same no change/ increased/ decreased/ overeating/ skipping meals/binge eating/not eating**

CHANGES IN APPETITE: **Yes/No** **Weight**: **gained/ lost/ same**

ALCOHOL: **never/ rarely/ daily drinks#: \_\_\_\_ Blackouts: Yes/ No**

SMOKING: **Yes/No How Much? \_\_\_\_**

DRUGS: **never/daily/monthly/ Which Drugs? \_\_\_\_\_\_\_\_\_ When Last? \_\_\_\_\_\_\_**

EXERCISE: **never/ occasionally/ once a week/ nearly every day**

SUICIDE: **thoughts/no plan thoughts/with plan previous attempts/how many hospitalizations: \_\_**

**NEW STRESS IN MY LIFE**: