

NORMAL SCREENING ASSESSMENT

Name of subject _____ Sex _____

Date of Birth _____ Date of Test _____

1. Have you ever had any major illness mental or physical in the past or recently?

2. Have you ever taken any prescribed drugs? What kind of nonprescribed drugs do you use recreationally in the past or recently? Alcohol use?

3. Did you ever hear or see things that other people couldn't hear or see, such as noises, or the voices of people?

4. Can you think clearly or is there any interference with your thoughts?

5. Have you ever felt people were following you or trying to hurt you?

6. Have you ever afraid to hurt yourself or thought of killing yourself?

7. Have you ever have to repeatedly wash hands or check locks, or have a silly thought or song go through your mind that you couldn't stop?

8. In the past, has there been a period of time when you were feeling depressed or down most of the day nearly every day?

9. Was there ever a time in your life when you were a lot less interested in most things or unable to enjoy the things you used to enjoy?

10. Have you ever had a problem, recently or in the past, with concentrating, sleeping, thinking, weight (lose or gain), or "energy" levels?

11. Have you felt particularly full of energy, almost too cheerful, super-efficient at work or school, or felt you had special powers or talents give out of the ordinary?

12. Have there been times lately or in the past when you have been very anxious or frightened? Do you worry a lot?

13. Have your parents or siblings ever had any major illness in the past or recently?

14. How many brothers and sisters do you have?

15. Have there been any other things lately that I haven't covered?

Interviewer _____