Date: _____ Name: _____

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

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 **interest,** inability to enjoy things:		
2. Depressed or anxious **mood**:		crying spells panic attacks rumination and worry obsessions
3. Decreased or increased **sleep** (circle which):		*If sleep is a problem:* difficulty **falling** asleep difficulty **staying** asleep time I usually **go to bed**: ____; time I **fall asleep**: ___; time I **wake up**: _____. Total hours of sleep in 24 hour period (including naps): _____.
4. Decreased or increased **energy**:		feeling tired much of the time feeling unmotivated feeling "revved up" nervous energy
5. Decreased or increased **appetite**:		binge eating purging calorie restriction fasting frequent weighing use of laxatives to lose weight obsessing about food or weight
6. **Guilt feelings** or feelings of worthlessness or **failure**:		feeling of failure feeling of inadequacy feeling I did something very bad (even if I didn't)
7. Decreased **concentration** 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. **Suicidal thoughts**, 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 **alcohol**:		average daily alcohol use: _____; maximum: _____.
12. **Substance use** 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 **DEPRESSION** or **SADNESS** (0-10):	
14. Your feelings of **ANXIETY** (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?
Example: Lexapro	*10 mg*	*Once a day*	++	*Mild sedation*