Please circle your response. This questionnaire will help us understand how to help you.

How would you describe your emotional stress?	Angry, anxious, depressed, numb, hyper, grief	
How long have you been having Emotional Distress?	<1 day, <1 week, <1 month, <6 months, <1 year	
What do you think is causing your emotional stress?	Loss, family/friends, finances, medical, legal	
How would you rate the severity of your emotional stress?	-Select-1-2 Slight3-4 Mild5-6 Moderate7-8 Severe9-10 Unbearable	
Have you ever considered hurting, harming or killing yourself?	Yes	No
If you are having thoughts of hurting yourself, do you have a plan to kill yourself?	Yes	No
If you are having thoughts of hurting yourself, how likely do you think it is that you would act on suicidal thoughts in the future?	-Select- Very Likely, Likely, Possible, Unlikely, Impossible	
Has your emotional stress affected your daily activities?	Yes	No
Has your emotional stress affected your relationships with others?	Yes	No
Do your symptoms occur during a certain point in your menstrual cycle?	Yes	No
Do your symptoms occur during certain times of the year?	Yes	No
Have you ever hurt yourself in order to relieve stress or anxiety or to make yourself feel better?	Yes	No
Have you ever experienced any flashbacks or memories of a life-threatening or traumatic event?	Yes	No
Do you feel like this life is hopeless or has no purpose?	Yes	No
Have you ever had a period of time when you were so full of energy and your ideas came very rapidly, when you talked nearly non-stop, when you moved quickly from one activity to another, when you needed little sleep, and believed you could do almost anything?	Yes	No
Do you often have obsessions or unwanted ideas, images or impulses that intrude on your thinking?	Yes	No

Do you have any repeated urges or compulsions to do something that lessens feelings of anxiety?	Yes	No
Do you hear voices that bother you and you can't figure out where they are coming from?	Yes	No
Are you seeing things that other people cannot see?	Yes	No
Do you feel like you have any special abilities or talents that other people don't have?	Yes	No
Have you been feeling exhausted, tired, or fatigued most of the time?	Yes	No
Are you having trouble concentrating?	Yes	No
Do you have difficulty keeping your thoughts focused or are you easily distracted?	Yes	No
Have you felt little interest or pleasure in doing things?	Yes	No
Have you been having trouble with sleeping?	Yes	No
Have you had a change in your appetite?	-Select- No, Increase, Decrease	
Have you had unexplained weight changes?	-Select- No, Weight Gain, Weight Loss	
Have you had an experience that was so frightening, horrible, or unsettling that you have had nightmares or thought about it in the last month when you did not want to?	Yes	No
Do you have access to firearms in the home or elsewhere?	Yes	No