**Multiaxial Assessment**

Name:

**In the last year have you experienced any of the following:** (Check for yes answers only)

|  |  |  |
| --- | --- | --- |
|  |  | Yes |
| A | Failed to give close attention to details or make careless mistakes in schoolwork, work, or other activities. |  |
|  | Often have difficulty in sustaining attention to tasks or activities. |  |
|  | Do not seem to be listening when spoken to directly. |  |
|  | Often have difficulty following through with instructions and fail to finish schoolwork, chores, or duties in the workplace. |  |
|  | Have difficulty organizing tasks and activities. |  |
|  | Often avoid, dislike, or are reluctant to engage in tasks that require sustained mental effort. |  |
|  | Often loss things necessary for the completion of tasks or assignments. |  |
|  | Often easily distracted by extraneous stimuli. |  |
|  | Often forgetful in daily activities. |  |
| H | Often fidgeting or squirming. |  |
|  | Often leave your seat in a classroom or other setting in which remaining seated is expected. |  |
|  | Feelings of restlessness. |  |
|  | Often have difficulty playing or engaging in leisure activities quietly. |  |
|  | Often “on the go” or act as if “driven by a motor”. |  |
|  | Often blurt out answers before questions are completed |  |
|  | Often have difficulty waiting for your turn. |  |
|  | Often interrupt or intrude on others. |  |
| D | Have you felt depressed most of the day, nearly every day or has someone else thought you appeared to be depressed? |  |
|  | Have you or someone else noticed that you have had diminished interest or pleasure in all, or almost all activities? |  |
|  | Have you experienced any significant weight loss or weight gain or an increase or decrease in appetite? |  |
|  | Have you experienced a change in sleep, sleeping more or having trouble sleeping? |  |
|  | Have you or others noticed that you seem unable to sit still or slowed down? |  |
|  | Have you felt fatigued or a loss of energy? |  |
|  | Have you had any feelings of worthlessness or excessive or inappropriate guilt? |  |
|  | Have you or others noticed that you appear to have diminished concentration, or indecisiveness? |  |
|  | Have you had any recurrent thoughts of death or dying, thoughts of suicide, a suicide attempt, or a plan to commit suicide? |  |
|  | Have you experienced feelings of being helpless or hopeless? |  |
| M | Inflated self esteem, grandiosity, feeling on top of the world? |  |
|  | Decreased need for sleep? |  |
|  | More talkative then usual or pressure to keep talking? |  |
|  | Racing thoughts, flight of ideas, or an inability to keep up with how fast you are thinking? |  |
|  | Easily distracted or trouble concentrating on tasks? |  |
|  | Increase in goal directed activity or an inability to sit still? |  |
|  | Excessive involvement in pleasurable activities that have a high potential for painful consequences such as buying sprees, sexual indiscretions, gambling, drug or alcohol abuse, or foolish business investments? |  |
| P | Palpitations, pounding heart, or accelerated heart rate? |  |
|  | Sweating? |  |
|  | Trembling or shaking?Sensations of shortness of breath or smothering? |  |
|  | Feeling of choking? |  |
|  | Chest pain or discomfort? |  |
|  | Nausea or abdominal distress? |  |
|  | Feeling dizzy, unsteady, light headed, or faint? |  |
|  | Feeling as if things are unreal or detached from yourself? |  |
|  | Fear of losing control or going crazy? |  |
|  | Fear of dying? |  |
|  | Numbness or tingling sensations? |  |
|  | Chills or hot flashes?  |  |
| O | Do you experience thoughts, impulses, or images that are intrusive and inappropriate that cause you anxiety or distress? |  |
|  | Are the thoughts, impulses, and images more than simple excessive worries about real life problems? |  |
|  | Do you find yourself attempting to ignore or control the thoughts, impulses, and images by engaging in some other thought or action? |  |
|  | Are the thoughts, impulses, or images coming from your own mind or are they coming from another source? |  |
| C | In response to the thoughts, impulses, or images do you find yourself involved in repetitive behaviors or mental acts to help you resolve a sense of anxiety or distress? |  |
|  | Do you have behaviors or mental acts aimed at preventing or reducing distress or preventing some dreaded situation: However, these behaviors or mental acts are either not connected in a realistic way with what they are designed to neutralize or prevent or are clearly excessive? |  |
| G | Restlessness or feeling keyed up or on edge? |  |
|  | Being easily fatigued? |  |
|  | Difficulty concentrating or mind going blank? |  |
|  | Irritability? |  |
|  | Muscle tension? |  |
|  | Do you have difficulty falling asleep or staying asleep? |  |
| A | Do you find yourself refusing to maintain a body weight at or above a minimally normal weight for your age and height? |  |
|  | Do you have an intense fear of becoming fat? |  |
|  | Do you find your body weight or shape disturbing?  |  |
| B | Do you find yourself at times eating an amount of food that is larger than most people would eat during a similar period of time or under similar circumstances? |  |
|  | Do you experience a sense of lack of control during this same period of time? |  |
|  | Do you find yourself taking steps to avoid weight gain in relation to your eating behavior? (induce vomiting, use of laxatives, diuretics, fasting, or excessive exercise) |  |
| I | Have you experienced episodes of aggression which have resulted in destruction of property or someone getting hurt? |  |
|  | Was the degree of aggression out of proportion to the what caused it? |  |
|  |  |  |
|  |  |  |
|  |  |  |

Please continue to next page.

**Have you ever experienced any events that could be considered**

**traumatic? Yes\_\_\_ No \_\_**

**If Yes, please check the symptoms that apply to you. No detail is necessary at this time, but a one or two word answer to name the event such as car accident, robbery, rape, etc. would be appreciated.**

|  |  |
| --- | --- |
|   | Yes |
| Experienced, witnessed, or confronted an event or events with actual or threatened clear, serious injury of threat to physical integrity. Please name event(s): |  |
| Intense fear; Helplessness; Horror |  |
| Recurrent and intrusive distressing recollections. |  |
| Recurrent distressing dreams of the event(s). |  |
| Acting or feeling as if the traumatic event were recurring. |  |
| Intense distress at exposure to events that symbolize or resemble an aspect of the traumatic event (including anniversary.) |  |
| Physiological reactivity on exposure to internal or external cues that symbolize or resemble the event |  |
| Efforts to avoid thoughts/feelings/conversations associated. w/ trauma |  |
| Efforts to avoid activities/places/people that arouse recollections |  |
| Inability to recall an important aspect of the trauma |  |
| Marked diminished interest in significant activity |  |
| Feeling detachment or estranged from others |  |
| Restricted range of affect (Ex: unable to express feelings such as love or other emotions) |  |
| Sense of foreshortened future: (Thoughts that your life may be shortened from a normal life span.) |  |
|  |  |
| Difficulty falling or staying asleep |  |
| Irritability or outburst of anger |  |
| Difficulty concentrating |  |
| Hyper-vigilance  |  |
| Exaggerated startle response |  |
| Physiologic reactivity upon exposure to events that symbolize trauma |  |
|  |  |
| Symptoms have caused me problems with work, school, relationships, etc. |  |
| Symptoms have lasted for more than a month. |  |
|  |  |
| My symptoms started immediately following the event(s). |  |
| *My symptoms had a delayed onset.* |  |

**Other Comments:**