MID-ATLANTIC
BRAIN & NEUROLOGICAL
REHABILITATION

Mental & Mood History

Patient Name: _____ Date: _____

Have you noticed any of the following in the past 6 months? If yes, explain how often.

	Yes	No	If yes, explain how often.
Edgy restlessness			
Tire easily, easily fatigued			
Difficulty concentrating			
Irritability			
Increased muscle tension			
Disturbed sleep (quality, quantity, & architecture)			
Noticed any excessive sweating?			
Have you noticed it difficult to control your worrying?			
Have you noticed worrying causing distress or impairment in social, occupational, or other important areas of functioning?			
Feeling of embarrassment in public			
Great anxiety/worry when away from close friends or relatives			
Constant worry about contamination			
Washing hands more than 10 times a day			
Canceling out bad thoughts with good thoughts			
Ensuring symmetry in your body or objects around you			
Excessive concern with imperfections in this form			
Having to count or arrange objects more in the same order			

Have you noticed for 30 minutes or less any of the following in the past 6 months?

	Yes	No	If yes how often, how severe, how long did it last.
Severe fear or discomfort			
Chest pain/discomfort			
Chills/hot flashes/hair on end			
Choking sensation			
Feeling of not really being here			
Unsteady sensation, dizziness, vertigo, or feeling faint			
Awareness of the rate and rhythm of your heart			
Sweating & trembling (or shaking)			
Shortness of breath or hyperventilation			

How many hours a night are you sleeping? _____ hours

Is your sleep restless? ☐No ☐Yes

Do you have trouble falling asleep? ☐No ☐Yes

Do you have trouble waking up? ☐No ☐Yes

Do you snore? ☐No ☐Yes

Do you have trouble sleeping at night because of snoring or sleeping problems? ☐No ☐Yes

Are you drowsy during the day because you don't sleep enough? ☐No ☐Yes

Have you noticed for 30 minutes or less any of the following in the past 6 months?

	Yes	No	If yes how often, how severe, how long did it last.
Temporary loss of cognitive or thinking abilities			
Feelings of sadness, emptiness, or depressed mood throughout the majority of your day.			
Chills/hot flashes/hair on end			
Reduced interest in activities that are usually pleasurable such as hobbies, relationship interactions, etc.			
Difficulty with getting the amount of deep restorative sleep you used to get, regardless of how long you are in bed.			

Sleeping much more often that you usually do.			
Feelings of restlessness or being slowed down.			
Increased feelings of fatigue or reduced energy			
Feelings of worthlessness or unexplained guilt.			
Inability to focus thoughts or concentrate with normal clarity.			
Recurrent thoughts of death or dying.			
Thoughts of suicide			
Others note your mood seems sad or melancholic			
Others have noted you have agitated or slowed movements.			
Others note you seem indecisive.			
Does your mood seem sad, depressed, or melancholic only during certain times of the year?			
If you checked yes to any of the questions in this table, please indicate how many occurred within the same 2 week period: _____			
If you checked yes to any of the questions in this table, please indicate how long these symptoms tend to last: _____			

Have you noticed for 30 minutes or less any of the following in the past 6 months?

	Yes	No	If yes how often, how severe, how long did it last.
Increased sense or awareness of one's own sense of value and ability			
A reduced need for sleep			
Racing thoughts and ideas			
More talkative than usual			
Increased pleasurable activities that have a high risk (buying sprees, gambling, risky investing, sexual indiscretions, etc)			

Doctor's Notes: _____

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_____Doctor's Initials: _____