PIONEER
Community Hospital of Aberdeen

Outpatient Behavioral Health Screening Form

Patient Name:_____ Age: _____

Please check all that apply:

- ☐ Suicidal thoughts, gestures, plans, attempts
- ☐ Homicidal thoughts, gestures, plans, attempts
- ☐ Lethargy/fatigue
- ☐ Impaired concentration/attention
- ☐ Depressed mood
- ☐ Psychomotor retardation (a slowing down of thought and a reduction of physical movement
- ☐ Impaired or disorganized thinking
- ☐ Weight Change
- ☐ Change in appetite (+ or -)
- ☐ Sleep disturbance (too much or too little)
- ☐ Non-attentive to personal hygiene/ADL deficits
- ☐ Anxiety/panic attacks
- ☐ Mood Swings/ changes in personality
- ☐ Grief or loss of: Spouse____ Child____ Parent____ Friend____ Relative____
- ☐ Hallucinations: Visual____ Auditory____ Tactile (touch)____ Gustatory (taste) ____
- ☐ Delusions: Paranoid____ Somatically focused____ (focused on body functions, fear of disease or disorder, multiple somatic complaints where no physical basis can be found).
- ☐ Withdrawn/isolation/loss of interest in usual activities
- ☐ Memory Impairment
- ☐ Separation/divorce/widowed; marital /relationship conflicts
- ☐ Loss of independence/role; recent life changes
- ☐ Recent deterioration in functioning level
- ☐ Extreme agitation/psychomotor agitation
- ☐ Physical or verbal aggression/assaultive/opposition/defiant
- ☐ Irritability/extreme agitation or excitability

If the patient exhibits any of these symptoms, please fax this form to the Outpatient Behavioral Health Program for screening at 276-692-3003.
Any questions please feel free to call Lois Barbour at 276-692-3001.

Contact Name: _____ Phone:_____