



JONES SCREENING QUESTIONNAIRE FOR STRESS DISORDERS

NAME _____ DATE _____

IMPORTANT: Only circle “yes” if the symptoms described cause you *significant* distress and/or cause problems at work, home, or in relationships.

- NO YES Do you frequently have difficulty getting to sleep or staying asleep? Do you regularly feel unrested or function poorly during the day because you didn't get enough sleep or had poor quality sleep?
- NO YES Do you have anxiety or worry excessively (more than the average person) about things such as work, finances, loved ones? Have you found it difficult to control worry and anxiety?
- NO YES Do you have unexpected or out of the blue periods of intense fear associated with symptoms such as shakiness, shortness of breath, racing heart?
- NO YES Do you experience intense feelings of anxiety or fear that you will be humiliated or embarrassed in front of others? Do you avoid or anxiously endure things such as speaking in public, parties, dating, writing or eating in front of others?
- NO YES Are you bothered by intrusive thoughts or mental images? Do you have to perform repetitive behaviors (e.g. hand washing or checking), or mental rituals (e.g. counting, repeating words) to control anxiety or distress?
- NO YES Have you experienced a traumatic event(s) that caused actual or threatened serious sexual, or physical injury to you or others? As a result, do you have significant stress such as flashbacks, nightmares, persistent anxiety, or feelings of emotional numbness?
- NO YES Do you have times when you feel depressed or down most of the day, nearly every day? AND/OR have you lost interest, motivation, have low energy, or no pleasure in usual activities?
- NO YES Do you have chronic problems paying attention or concentrating due to either mind wandering or being easily distracted?
- NO YES Are you frequently hyperactive (mental or physical) finding it hard to relax or be still or quiet as though driven by a motor?
- NO YES Do you frequently do things impulsively that you regret or that cause you trouble as though you act first and think second?

CONTINUED ON BACK

IMPORTANT: Only circle “yes” if the symptoms cause you *significant* distress and/or cause problems at work, home, or relationships

- NO YES Do you ever have a period of time when you feel “up” or “high”, or so full of energy or so full of yourself that you get into trouble, or that other people think you are not your usual self? (Does not include drug or alcohol induced states)
- NO YES Have you or others been concerned about your alcohol consumption? Have you tried to cut down or felt guilty about drinking alcohol?
- NO YES Do you have eating binges or times when you eat a very large amount of food within a two-hour period?
- NO YES Do you have a lack/loss of interest in sex, decreased arousal; erectile dysfunction, or premature or delayed ejaculation (men); delayed or absent orgasm (woman)?
- NO YES Have other people expressed concerns that you are too thin?
- NO YES Are you preoccupied by or frequently stress over some aspect of your appearance, e.g., skin, face, hair, nose, genitals? This includes spending excessive time with grooming or looking in the mirror.

Circle ALL of the physical symptoms that apply to you:

Restless legs Daytime sleepiness Loud snoring Night sweats

Light headedness Dizziness Tremors/shakiness Tingling

Shortness of breath Heart racing Blurred vision Swelling

Fatigue Headaches Rashes Stomach/bowel problems

Urinary problems Hair loss

Pain (explain type)_____

Menstrual/hormone problems (Explain type)_____

Other (explain)_____