Star Health Care LLC
MOOD Questionnaire

Answer all questions listed below to the best of your ability. If this form is not filed out in its entirety it will be requested to be filled out prior to conducting interview, receiving treatment, or having prescriptions refilled.

Name_____ **M.I**_____

Date of Birth:_____ **SSN:**_____

Options:

NO YES

1. Has there ever been a period of time when you were not your usual self and...

   …you were so irritable that you shouted at people or started fights or arguments? _____

   …you felt much more self-confident than usual? _____

   …you got much less sleep than usual and found you didn't really miss it? _____

   …you were much more talkative or spoke faster than usual? _____

   …thoughts raced through your head, or you couldn't slow your mind down? _____

   …you were so easily distracted by things around you that you had trouble concentrating or staying on track? _____

   …you had much more energy than usual? _____

   …you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night? _____

   …you were much more interested in sex than usual? _____

   …you were much more active or did many more things than usual? _____

   …you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky? _____

   …you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky? _____

2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time? _____
3. How much of a problem did any of these cause you — like being able to work; having family, money, or legal troubles; getting into arguments or fights? _____
4. Have any of your blood relatives (i.e., children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder? _____
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder? _____

Disclosure and Acknowledgement:

By signing you confirm all selections are true or have been provided by a representative of the patient or by the patient. Only the patient or the legal representative may sign or provide data in this form. The legal representative must first be acknowledged by the state and have on file a copy of the records with Star Health Care LLC.

You also acknowledge that this data will be attached to the chart at the time of the visit and will be used as a direct reflection of symptoms experienced by the patient, and not by the one signing the form. The information is to be presented as subjective

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data which will be used at the time of the visit to originate talking points to better support and formulate a plan-of-care for treatment measures.

This information will not be given out without legal release from the patient or legal representative at any time.

Patient Signature

Signature_____**Date**_____

Guardian or Authorized Representative Signature

Signature_____**Date**_____

FOR PHYSICIAN USE ONLY

Evaluation:_____

Notes: