OPTIONAL MODULE 4:
PSYCHECK

FOR STAFF ONLY

UR Number:

Surname:

Given name:

Date of birth:

(Please fill in if no label available)

SELF REPORTING QUESTIONNAIRE

(CLIENT OR CLINICIAN TO COMPLETE)

The *PsyCheck* Screening Tool is designed to be used in conjunction with the *PsyCheck* Clinical Treatment Guidelines.

1. Please tick the 'Yes' box if you have had this symptom in the last 30 days.
2. Look back over the questions you have ticked. For every one you answered 'Yes', please put a tick in the circle if you had that problem at a time when you were NOT using alcohol or other drugs.

1.	Do you often have headaches?	☐ No	☐ Yes	○
2.	Is your appetite poor?	☐ No	☐ Yes	○
3.	Do you sleep badly?	☐ No	☐ Yes	○
4.	Are you easily frightened?	☐ No	☐ Yes	○
5.	Do your hands shake?	☐ No	☐ Yes	○
6.	Do you feel nervous?	☐ No	☐ Yes	○
7.	Is your digestion poor?	☐ No	☐ Yes	○
8.	Do you have trouble thinking clearly?	☐ No	☐ Yes	○
9.	Do you feel unhappy?	☐ No	☐ Yes	○
10.	Do you cry more than usual?	☐ No	☐ Yes	○
11.	Do you find it difficult to enjoy your daily activities?	☐ No	☐ Yes	○
12.	Do you find it difficult to make decisions?	☐ No	☐ Yes	○
13.	Is your daily work suffering?	☐ No	☐ Yes	○
14.	Are you unable to play a useful part in life?	☐ No	☐ Yes	○
15.	Have you lost interest in things?	☐ No	☐ Yes	○
16.	Do you feel that you are a worthless person?	☐ No	☐ Yes	○
17.	Has the thought of ending your life been on your mind?	☐ No	☐ Yes	○
18.	Do you feel tired all the time?	☐ No	☐ Yes	○
19.	Do you have uncomfortable feelings in the stomach?	☐ No	☐ Yes	○
20.	Are you easily tired?	☐ No	☐ Yes	○

Total score (add circles only): _____

FOR STAFF ONLY

Clinician name: Position: Signature: Date:

PsyCheck

FOR STAFF ONLY

UR Number:

Surname:

Given name:

Date of birth:

(Please fill in if no label available)

INTERPRETATION/SCORE

Score of 0*	No symptoms of depression, anxiety and/or somatic complaints indicated at this time. **Action:** Re-screen using the *PsyCheck* Screening Tool after 4 weeks if indicated by past mental health questions or other information. Otherwise monitor as required.
Score of 1–4*	Some symptoms of depression, anxiety and/or somatic complaints indicated at this time. **Action:** Give the first session of the *PsyCheck* Intervention and screen again in 4 weeks.
Score of 5+*	Considerable symptoms of depression, anxiety and/or somatic complaints indicated at this time. **Action:** Offer Sessions 1–4 of the *PsyCheck* Intervention.

Re-screen using the *PsyCheck* Screening Tool at the conclusion of four sessions.

If no improvement in scores evident after re-screening, consider referral.

* Regardless of the client's total score on the SRQ, consider intervention or referral if in significant distress.

FOR STAFF ONLY

Clinician name: Position: Signature: Date: