Subject ID _______

Date _______

Behavior Rating Scale
Self-Report

Please rate yourself for the period for the last _______________

0 = none, 1 = slight, 2 = mild, 3 = moderate, 4 = severe

Item					
<u>DSM-5 Symptoms</u>					
1. Angry, irritable, frustrated	0	1	2	3	4
2. Anxious, nervous	0	1	2	3	4
3. Depressed mood, sad	0	1	2	3	4
4. Difficulty concentrating	0	1	2	3	4
5. Increased appetite, hungry, weight gain	0	1	2	3	4
6. Insomnia, sleep problems, awakening at night	0	1	2	3	4
7. Restless	0	1	2	3	4
<u>Other Validated Symptom</u>					
8. Desire or craving to smoke	0	1	2	3	4
<u>Other Possible Symptoms</u>					
9. Constipation	0	1	2	3	4
10. Coughing	0	1	2	3	4
11. Decreased pleasure from events	0	1	2	3	4
12. Dizziness	0	1	2	3	4
13. Drowsy	0	1	2	3	4
14. Impatient	0	1	2	3	4
15. Impulsive	0	1	2	3	4

<u>Physical Changes</u>

Heart rate ____________ bpm

Weight _______________ kg