Rachel Williams

Oceans Reflection

Safety & Quality:
To help maintain a safe and quality environment I helped observe patients' behavior and performed assessments such as suicide risk assessments, depression assessments, and mood disorder assessments. I was very straight forward yet calm with my questions pertaining to potential and risk for suicide to understand the patient's level of risk. I made sure not to bring unsafe or harmful objects into the patient area such as pens and clipboards. I verified the patient's name before discussing any information with them to ensure privacy and safety.

Clinical Judgment:
As I listened during group therapy, I noticed how the therapist asked many open-ended questions, so it initiates a more descriptive response from patients which helps them to express their feelings better instead of just answering "yes" or "no." The tone was very calm and non-judgmental which helps the patients feel more comfortable and trusting of who they are talking around. I can use this to further improve my practice by using this as a reminder to always use a calm tone when talking to patients and communicating with them in a non-judgmental way. This builds trust with patients and helps them to feel safe and open with who they are talking to. I have learned that the way a nurse approaches, talks to, and listens to their patients are important factors in therapeutic communication.

Patient Centered Care:
One patient in the group therapy has severe depression and was a new admit to the facility. He/she is very distant and closed off from others. A priority intervention for the nurse is to use therapeutic communication such as using a calm and soft tone, sitting at eye level with the patient, and allowing silence when the patient needs time to gather their thoughts. A recommendation for this client would be to attend one-on-one therapy and to try to express their feelings instead of trying to work through their emotions by themselves.

Communication & Collaboration:
I utilized therapeutic communication by sitting down with the patient while being an active listener, acknowledging their feelings, asking open-ended questions, and showing empathy towards them. I used collaboration by discussing the patient's behaviors/ interactions with the clinical instructor.

Feelings:
At the beginning of the clinical shift, I felt some nervousness because I have never been around patients that were admitted solely for mental health problems. I wasn't sure I would communicate with them in the most appropriate way. After talking with some of the patients, I really empathized with their emotional struggles. I felt the outcome was very good, and felt I communicated with the patients in a therapeutic way because they were able to open up to me and tell me about their struggles and feelings. I think the most important feeling I had was expressing to these patients that their lives are important and that they deserve to live a happy and loving life.

Student Name: Rachel Williams **Unit:** _____ **Pt. Initials:** JL **Date:** 2-10-26

Medication Worksheet – Current Medications & PRN for Last 24 Hours

Allergies: NKDA

Primary IV Fluid and Infusion Rate (ml/hr)	Circle IVF Type	Rationale for IVF	Lab Values to Assess Related to IVF	Contraindications/Complications
✓ N/A	Isotonic/ Hypotonic/ Hypertonic			

Generic Name	Pharmacologic Classification	Therapeutic Reason	Dose, Route & Schedule	Correct Dose? If not, what is correct dose?	IVP – List solution to dilute and rate to push. IVPB – List mL/hr and time to give	Adverse Effects	Appropriate Nursing Assessment, Teaching, Interventions (Precautions/Contraindications, Etc.)
Oxcarbazepine	Anti-convulsant		300 mg 1 tab BID PRN	(Y) N		Dizziness, drowsiness, double vision, fatigue, nause, HA	1. Can cause hyponatremia, monitor sodium levels 2. Monitor for increased suicidal thoughts 3. Report to nurse any skin rashes 4. Avoid alchol
Clonazepam	Benzo-diazepine		0.5 mg 1 tab BID PRN	(Y) N		Drowsiness, impaired coordination, fatigue, confusion	1. Monitor for respiratory depression 2. Monitor for behavior changes, (suicidal ideation) 3. Fall precautions 4. Monitor for signs of dependency/withdrawal.
Olanzapine	Atypical Anti-psychotics		10 mg 1 tab BID PRN	(Y) N		increased appetite, weight gain, sedation, drowsiness	1. Monitor weight + blood glucose 2. Monitor for orthostatic hypotension 3. Monitor for involuntary movements of face/tongue 4. Provide relief for dry mouth
				Y N			1. 2. 3. 4.
				Y N			1. 2. 3. 4.

Rachel Williams

PMH Critical Thinking Sheet

DSM-5 Diagnosis and Brief Pathophysiology: MDD

Disturbance of mood involving depression or loss of interest or pleasure in usual activities or pastimes.

DSM-5 Criteria for your patient's diagnosis: At least 5 >

- Depressed mood most of the day, nearly everyday.
- Markedly diminished interest or pleasure in all activities.
- Significant weight loss when not dieting.
- insomnia or hypersomnia nearly everyday
- fatigue or loss of energy nearly every day

Psychosocial Stressors (Legal, Environmental, Relational, Developmental, Educational, Substance Use, etc.)

Excessive self-critisism, relationship conflict, divorce, emotional + physical abuse, social isolation, loneliness, anxiety due to parenting and PPD.

Therapeutic Communication & Nurse Patient Relationship:

Communication strategy:

Non-judgemental, direct talk about suicide, build trust, reduce hopelessness and isolation, calm and consistent.

Stage of nurse-patient relationship:

orientation phase

Therapeutic communication techniques appropriate for this patient:

Being present for the patient and listening.

Use supportive, non-judemental language.

Ask direct, calm questions

Be consistent to build trust.

Communication approaches to avoid:

Avoid sarcastic humor.

Avoid statements that exaggerate the truth.

Avoid minimizing or invalidating their pain

Avoid reacting with shock

Avoid using forced positivity

Plan of Care: prevent self-harm, maintain patient safety at all times

Patient problem: Risk for suicide

Related to (etiology):

Depressed mood, history of prior suicide attempts, divorced, states desire to die.

~~As evidenced by (signs & symptoms)~~:

Outcome/Goal:

Client commits no acts of self-harm, client verbalizes no thoughts of suicide.

Current Treatment & Interventions:

1. Create a safe environment for the client. Remove potentially harmful objects. Supervise closely during meals and med administration.

Rationale: Client safety is a nursing priority

2. Formulate a short-term verbal or written contract with the client that he/she will not harm self during specific time period.

Rationale: discussion of suicidal feelings with a trusted individual provides some relief to client.

3. Secure promise from client that he or she will seek out a staff member or support person if thoughts of suicide emerge.

Rationale: Discussion of feelings before a crisis situation may help provide assistance.

4. Maintain close observations of client, depending on level of suicide precaution.

Rationale:

Close observation is necessary to ensure that client does not harm self in any way.

Student name:

Rachel Williams

HAMILTON DEPRESSION RATING SCALE (HAM-D)

(To be administered by a health care professional)

Patient Name JL **Today's Date** 2-10-26

The HAM-D is designed to rate the severity of depression in patients. Although it contains 21 areas, calculate the patient's score on the first 17 answers.

[1] **1. DEPRESSED MOOD**
(Gloomy attitude, pessimism about the future, feeling of sadness, tendency to weep)
0 = Absent
1 = Sadness, etc.
2 = Occasional weeping
3 = Frequent weeping
4 = Extreme symptoms

[3] **2. FEELINGS OF GUILT**
0 = Absent
1 = Self-reproach, feels he/she has let people down
2 = Ideas of guilt
3 = Present illness is a punishment; delusions of guilt
4 = Hallucinations of guilt

[4] **3. SUICIDE**
0 = Absent
1 = Feels life is not worth living
2 = Wishes he/she were dead
3 = Suicidal ideas or gestures
4 = Attempts at suicide

[0] **4. INSOMNIA - Initial**
(Difficulty in falling asleep)
0 = Absent
1 = Occasional
2 = Frequent

[0] **5. INSOMNIA - Middle**
(Complains of being restless and disturbed during the night. Waking during the night.)
0 = Absent
1 = Occasional
2 = Frequent

[0] **6. INSOMNIA - Delayed**
(Waking in early hours of the morning and unable to fall asleep again)
0 = Absent
1 = Occasional
2 = Frequent

[3] **7. WORK AND INTERESTS**
0 = No difficulty
1 = Feelings of incapacity, listlessness, indecision and vacillation
2 = Loss of interest in hobbies, decreased social activities
3 = Productivity decreased
4 = Unable to work. Stopped working because of present illness only. (Absence from work after treatment or recovery may rate a lower score).

[0] **8. RETARDATION**
(Slowness of thought, speech, and activity; apathy; stupor.)
0 = Absent
1 = Slight retardation at interview
2 = Obvious retardation at interview
3 = Interview difficult
4 = Complete stupor

[0] **9. AGITATION**
(Restlessness associated with anxiety.)
0 = Absent
1 = Occasional
2 = Frequent

[4] **10. ANXIETY - PSYCHIC**
0 = No difficulty
1 = Tension and irritability
2 = Worrying about minor matters
3 = Apprehensive attitude
4 = Fears

HAMILTON DEPRESSION RATING SCALE (HAM-D)

(To be administered by a health care professional)

[2] **11. ANXIETY - SOMATIC**
Gastrointestinal, indigestion
Cardiovascular, palpitation, Headaches
Respiratory, Genito-urinary, etc.
0 = Absent
1 = Mild
2 = Moderate
3 = Severe
4 = Incapacitating

[2] **12. SOMATIC SYMPTOMS - GASTROINTESTINAL**
(Loss of appetite , heavy feeling in abdomen; constipation)
0 = Absent
1 = Mild
2 = Severe

[1] **13. SOMATIC SYMPTOMS - GENERAL**
(Heaviness in limbs, back or head; diffuse backache; loss of energy and fatiguability)
0 = Absent
1 = Mild
2 = Severe

[1] **14. GENITAL SYMPTOMS**
(Loss of libido, menstrual disturbances)
0 = Absent
1 = Mild
2 = Severe

[1] **15. HYPOCHONDRIASIS**
0 = Not present
1 = Self-absorption (bodily)
2 = Preoccupation with health
3 = Querulous attitude
4 = Hypochondriacal delusions

[2] **16. WEIGHT LOSS**
0 = No weight loss
1 = Slight
2 = Obvious or severe

[0] **17. INSIGHT**
(Insight must be interpreted in terms of patient's understanding and background.)
0 = No loss
1 = Partial or doubtfull loss
2 = Loss of insight

TOTAL ITEMS 1 TO 17: 24
0 - 7 = Normal
8 - 13 = Mild Depression
14-18 = Moderate Depression
19 - 22 = Severe Depression
≥ 23 = Very Severe Depression

[1] **18. DIURNAL VARIATION**
(Symptoms worse in morning or evening. Note which it is.)
0 = No variation
1 = Mild variation; AM (✓) PM ( )
2 = Severe variation; AM ( ) PM ( )

[3] **19. DEPERSONALIZATION AND DEREALIZATION**
(feelings of unreality, nihilistic ideas)
0 = Absent
1 = Mild
2 = Moderate
3 = Severe
4 = Incapacitating

[1] **20. PARANOID SYMPTOMS**
(Not with a depressive quality)
0 = None
1 = Suspicious
2 = Ideas of reference
3 = Delusions of reference and persecution
4 = Hallucinations, persecutory

[1] **21. OBSESSIONAL SYMPTOMS**
(Obsessive thoughts and compulsions against which the patient struggles)
0 = Absent
1 = Mild
2 = Severe

* Adapted from Hamilton, M. *Journal of Neurology, Neurosurgery, and Psychiatry.* 23:56-62, 1960.

NURSING SHIFT ASSESSMENT

DATE: 2/10/26

SHIFT: ☑ Day(7A-7P) ☐ Night(7P-7A)

Label
Name: JL
MR#: _____ D.O.B. _____

Orientation
☑ Person
☑ Place
☑ Time
☑ Situation

Affect
☐ Appropriate
☑ Inappropriate
☑ Flat
☑ Guarded
☐ Improved
☐ Blunted

ADL
☑ Independent
☐ Assist
☐ Partial Assist
☐ Total Assist

Motor Activity
☑ Normal
☐ Psychomotor retardation
☐ Psychomotor agitation
☐ Posturing
☐ Repetitive acts
☐ Pacing

Mood
☐ Irritable
☑ Depressed
☐ Anxious
☐ Dysphoric
☐ Agitated
☐ Labile
☐ Euphoric

Behavior
☑ Withdrawn
☑ Suspicious
☐ Tearful
☐ Paranoid
☑ Isolative
☐ Preoccupied
Demanding
☐ Aggressive
☐ Manipulative
☐ Complacent
☐ Sexually acting out
☐ Cooperative
☑ Guarded
☐ Intrusive

Thought Processes
☑ Goal Directed ☐ Tangential ☐ Blocking
☐ Flight of Ideas ☐ Loose association ☑ Indecisive
☐ Illogical ☐ Delusions:) (type)_____

Thought Content
☐ Obsessions ☐ Compulsions ☑ Suicidal thoughts
☑ Hallucinations: ☑ Auditory ☐ Visual ☐ Olfactory ☐ Tactile ☐ Gustatory
☑ Worthless ☐ Somatic ☐ Assaultive Ideas ☐ Logical
☑ Hopeless ☐ Helpless ☐ Homicidal thoughts

Pain: Yes (No) ***Pain scale score*** _____ ***Locations*** _____
Is pain causing any physical impairment in functioning today ☐ No If yes explain _____

Nursing Interventions:
☑ Close Obs. q15 ☑ Ind. Support ☐ Reality Orientation ☐ Toilet Q2 w/awake ☐ 1 to 1 Observation _____ reason (specify)
☑ Milieu Therapy ☑ Monitor Intake ☑ Encourage Disclosure ☐ Neuro Checks ☑ Rounds Q2
☑ V/S ☑ O2 sat. ☑ Tx Team ☑ Wt. Monitoring ☐ Elevate HOB ☐ MD notified _____
☑ Nursing group/session (list topic): ACEs
☐ ADLs assist ☐ I&O ☐ PRN Med per order Clonazepam - 1 tab 0.5 mg BID

☐ ***DOCUMENT ABNORMAL OCCURENCES IN MULTIDISCIPLINARY NOTES*** *(violence, suicide, elope, fall, physical health)* ***DAILY SUICIDE RISK ASSESSMENT* Note – for frequent assessment purposes, Question 1 has been omitted***	***Since Last Contact***	
Ask Question 2*	***YES***	***NO***
2) ***Have you actually had thoughts about killing yourself?***	***LOW***	
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6		
3) ***Have you been thinking about how you might do this?***	***MOD***	
4) ***Have you had these thoughts and had some intention of acting on them?*** ***E.g., "I thought about taking an overdose, but I never made a specific plan as to when where or how I would actually do it....and I would never go through with it."***	***HIGH*** ✓	
5) ***Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?*** ***As opposed to "I have the thoughts, but I definitely will not do anything about them."***	***HIGH*** ✓	
6) ***Have you done anything, started to do anything, or prepared to do anything to end your life?*** ***Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.***	***HIGH*** ✓	

☐ ***Low Risk*** ☐ ***Moderate Risk*** ■ ***High Risk***

Nurse Signatures) Rachel Williams *Date:* 2/10/26 *Time:* 0920

REVIEW OF SYSTEMS

Cardio/Pulmonary:
☐ WNL ☐ Elevated B/P ☐ ↓ B/P
☐ Chest Pain
☐ Edema: ☐ upper ☐ lower

Respiratory/Breath sounds:
☐ Clear ☐ Rales ☐ Crackles ☐ Wheezing
☐ Cough ☐ S.O. B Other: _____
☐ O2 @ ____ l/min ☐ Cont. ☐ PRN
Via ☐ nasal cannula ☐ face mask

Neurological / L.O.C.:
☐ Unimpaired ☐ Lethargic ☐ Sedated
☐ Dizziness ☐ Headache ☐ Seizures
☐ Tremors ☐ Other _____

Musculoskeletal/Safety:
☐ Ambulatory ☐ MAE ☐ Full ROM
☐ Walker ☐ W/C ☐ Immobile
☐ Pressure ulcer ☐ Unsteady gait
☐ Risk for pressure ulcer
☐ Reddened area(s)

Nutrition/Fluid:
☐ Adequate ☐ Inadequate ☐ Dehydrated
☐ Supplement ☐ Prompting ☐ Other _____
new onset of choking risks assessed

Skin:
☐ Bruises ☐ Tear ☐ No new skin issues
☐ ~~Wound~~(s) *(see Wound Care Packet)*
☐ Abrasion ☐ Integumentary Assess
☐ Other: _____

Elimination:
☐ Continent ☐ Incontinent ☐ Catheter
☐ Diarrhea ☐ OTHER _____

Hours of Sleep: ____ ***Day*** ***Night***

At Risk for Falls: ☐ ***Yes*** ☐ ***No***

At Risk for FALL Precautions:
☐ Arm Band ☐ Nonskid footwear
☐ BR light ☐ ambulate with assist
☐ Call bell ☐ Clear path
☐ Edu to call for assist ☐ Bed alarm
☐ Chair alarm ☐ 1:1 observation level
☐ Assist with ADLs ☐ Geri Chair
☐ Ensure assistive devices near
☐ Other _____

NURSING SHIFT ASSESSMENT

DATE: 2/11/26 SHIFT: ☑ Day(7A-7P) ☐ Night(7P-7A)

Label
Name: BG
MR#: _____ D.O.B. _____

Orientation
☑ Person
☑ Place
☑ Time
☑ Situation

Affect
☑ Appropriate
☐ Inappropriate
☐ Flat
☐ Guarded
☑ Improved
☐ Blunted

ADL
☑ Independent
☐ Assist
☐ Partial Assist
☐ Total Assist

Motor Activity
☑ Normal
☐ Psychomotor retardation
☐ Psychomotor agitation
☐ Posturing
☐ Repetitive acts
☐ Pacing

Mood
☐ Irritable
☑ Depressed
☐ Anxious
☐ Dysphoric
☐ Agitated
☐ Labile
☐ Euphoric

Behavior
☐ Withdrawn
☐ Suspicious
☐ Tearful
☐ Paranoid
☐ Isolative
☐ Preoccupied
☐ Aggressive
☐ Manipulative
☐ Complacent
☑ Sexually acting out
☑ Cooperative
☐ Guarded
☐ Intrusive
Demanding

Thought Processes
☑ Goal Directed ☐ Tangential ☐ Blocking
☐ Flight of Ideas ☐ Loose association ☐ Indecisive
☐ Illogical ☐ Delusions:) (type)_____

Thought Content
☑ Obsessions ☐ Compulsions ☐ Suicidal thoughts
☐ Hallucinations: ☐ Auditory ☐ Visual ☐ Olfactory ☐ Tactile ☐ Gustatory
☐ Worthless ☐ Somatic ☐ Assaultive Ideas ☐ Logical
☑ Hopeless ☑ Helpless ☐ Homicidal thoughts

Pain: Yes / No ***Pain scale score*** 9 ***Locations*** right leg - post surgery pain
Is pain causing any physical impairment in functioning today No ☑ If yes explain doesn't want to walk around much.

Nursing Interventions:
☑ Close Obs. q15
☑ Milieu Therapy
☑ V/S ☑ O2 sat.
☑ Nursing group/session (list topic): strengths exploration
☐ ADLs assist
☑ Ind. Support
☑ Monitor Intake
☑ Tx Team
☐ I&O
☐ Reality Orientation
☑ Encourage Disclosure
☑ Wt. Monitoring
☐ PRN Med per order_____
☐ Toilet Q2 w/awake
☐ Neuro Checks
☐ Elevate HOB
☐ 1 to 1 Observation _____ reason (specify)
☑ Rounds Q2
☐ MD notified _____

☐ ***DOCUMENT ABNORMAL OCCURENCES IN MULTIDISCIPLINARY NOTES*** *(violence, suicide, elope, fall, physical health)* ***DAILY SUICIDE RISK ASSESSMENT* Note – for frequent assessment purposes, Question 1 has been omitted***	***Since Last Contact***	
Ask Question 2*	***YES***	***NO***
2) ***Have you actually had thoughts about killing yourself?***	LOW	✓
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6		
3) ***Have you been thinking about how you might do this?***	MOD	
4) ***Have you had these thoughts and had some intention of acting on them?*** ***E.g., "I thought about taking an overdose, but I never made a specific plan as to when where or how I would actually do it....and I would never go through with it."***	HIGH	
5) ***Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?*** ***As opposed to "I have the thoughts, but I definitely will not do anything about them."***	HIGH	
6) ***Have you done anything, started to do anything, or prepared to do anything to end your life?*** ***Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.***	HIGH	✓

☐ ***Low Risk*** ☐ ***Moderate Risk*** ☐ ***High Risk***

Nurse Signature(s) Rachel Williams Date: 2/11/26 Time: 0845

REVIEW OF SYSTEMS

Cardio/Pulmonary:
☐ WNL ☐ Elevated B/P ☐ ↓ B/P
☐ Chest Pain
☐ Edema: ☐ upper ☐ lower

Respiratory/Breath sounds:
☐ Clear ☐ Rales ☐ Crackles ☐ Wheezing
☐ Cough ☐ S.O. B Other: _____
☐ O2 @ ____ l/min ☐ Cont. ☐ PRN
Via ☐ nasal cannula face mask

Neurological / L.O.C.:
☐ Unimpaired ☐ Lethargic ☐ Sedated
☐ Dizziness ☐ Headache ☐ Seizures
☐ Tremors ☐ Other_____

Musculoskeletal/Safety:
☐ Ambulatory ☐ MAE ☐ Full ROM
☐ Walker ☐ W/C ☐ Immobile
☐ Pressure ulcer ☐ Unsteady gait
☐ Risk for pressure ulcer
☐ Reddened area(s)

Nutrition/Fluid:
☐ Adequate ☐ Inadequate ☐ Dehydrated
☐ Supplement ☐ Prompting ☐ Other_____
new onset of choking risks assessed

Skin:
☐ Bruises ☐ Tear ☐ No new skin issues
☐ ~~Wound~~(s) *(see Wound Care Packet)*
☐ Abrasion ☐ Integumentary Assess
☐ Other: _____

Elimination:
☐ Continent ☐ Incontinent ☐ Catheter
☐ Diarrhea ☐ OTHER_____

Hours of Sleep: ____ ***Day*** ***Night***

At Risk for Falls: ☐ ***Yes*** ☐ ***No***

At Risk for FALL Precautions:
☐ Arm Band ☐ Nonskid footwear
☐ BR light ☐ ambulate with assist
☐ Call bell ☐ Clear path
☐ Edu to call for assist ☐ Bed alarm
☐ Chair alarm ☐ 1:1 observation level
☐ Assist with ADLs ☐ Geri Chair
☐ Ensure assistive devices near
☐ Other _____

Rachel Williams

Mood Disorder Questionnaire (MDQ)

Name: BD Date: 2-11-26

Instructions: Check (☑) the answer that best applies to you.
Please answer each question as best you can.

	Yes	No
1. Has there ever been a period of time when you were not your usual self and...		
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	☑	○
...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 active or did many more things 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 did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	☑	○
...spending money got you or your family in trouble?	☑	☑
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time? *Please check 1 response only.*	☑	○
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? *Please check 1 response only.* ○ No problem ○ Minor problem ☑ Moderate problem ○ Serious problem		
4. Have any of your blood relatives (ie, 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?	☑	○

This questionnaire should be used as a starting point. It is not a substitute for a full medical evaluation. Bipolar disorder is a complex illness, and **an accurate, thorough diagnosis can only be made through a personal evaluation by your doctor.**

Adapted from Hirschfeld R, Williams J, Spitzer RL, et al. Development and validation of a screening instrument for bipolar spectrum disorder: the Mood Disorder Questionnaire. *Am J Psychiatry.* 2000;157:1873-1875.