

Brief Symptom Inventory (BSI)

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Description of Measure Purpose To identify self-reported clinically relevant psychological symptoms in adolescents and adults.

First Name: _____

Last Name: _____

Date of birth: _____ dd / mm / yyyy

Date of assessment: _____ dd / mm / yyyy

Assessor's First Name: _____

Assessor's Last Name: _____

Please rate each item based on how much you were bothered by that symptom during the past week, including today. Use the following scale for your responses: 0 - Not at all, 1 - A little bit, 2 - Moderately, 3 - Quite a bit, 4 - Extremely

Headaches

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

Nausea or upset stomach

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

Pain in heart or chest

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

Trouble concentrating

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

Unwanted thoughts

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

Having to do things very slowly to ensure correctness

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

Feeling uncomfortable around others

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

Feeling inferior to others

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

Feeling easily hurt by criticism or slight

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

Feeling no interest in things

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

Feeling low in energy or slowed down

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

Blaming yourself for things

☐ ☐ ☐ ☐ ☐

0 1 2 3 4

Nervousness or shakiness inside

☐ ☐ ☐ ☐ ☐

0 1 2 3 4

Feeling fearful

☐ ☐ ☐ ☐ ☐

0 1 2 3 4

Feeling tense or keyed up

☐ ☐ ☐ ☐ ☐

0 1 2 3 4

Feeling easily annoyed or irritated

☐ ☐ ☐ ☐ ☐

0 1 2 3 4

Temper outbursts that you could not control

☐ ☐ ☐ ☐ ☐

0 1 2 3 4

Having urges to beat, injure, or harm someone

☐ ☐ ☐ ☐ ☐

0 1 2 3 4

Feeling afraid to go out of your house alone

☐ ☐ ☐ ☐ ☐

0 1 2 3 4

Avoiding certain things, places, or activities

☐ ☐ ☐ ☐ ☐

0 1 2 3 4

Feeling terrified or panic-stricken

☐ ☐ ☐ ☐ ☐

0 1 2 3 4

Feeling that most people cannot be trusted

☐ ☐ ☐ ☐ ☐

0 1 2 3 4

Feeling that you are watched or talked about by others

☐ ☐ ☐ ☐ ☐

0 1 2 3 4

Feeling that others are to blame for your troubles

☐ ☐ ☐ ☐ ☐

0 1 2 3 4

Hearing voices that other people do not hear

☐ ☐ ☐ ☐ ☐

0 1 2 3 4

Having thoughts that are not your own

☐ ☐ ☐ ☐ ☐

0 1 2 3 4

Having visions or seeing things that other people do not see

☐

☐

☐

☐

☐

0

1

2

3

4

Patient's Responses/Comments

Assessor's Notes

Patient's signature

Date: dd / mm / yyyy

Assessor's signature

Date: dd / mm / yyyy