Brief Symptom Inventory (BSI)

Patient Information

Name

Date of birth

Date of assessment

Assessor's name

Instructions:

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

Symptom Assessment

Statement	Rating (0-4)
Somatization	
Headaches	
Nausea or upset stomach	
Pain in heart or chest	
Others: _____	
Obsessive-Compulsive	
Trouble concentrating	
Unwanted thoughts	
Having to do things very slowly to ensure correctness	
Others: _____	
Interpersonal Sensitivity	
Feeling uncomfortable around others	

Feeling inferior to others	
Feeling easily hurt by criticism or slight	
Others: _____	
Depression	
Feeling no interest in things	
Feeling low in energy or slowed down	
Blaming yourself for things	
Others: _____	
Anxiety	
Nervousness or shakiness inside	
Feeling fearful	
Feeling tense or keyed up	
Others: _____	
Hostility	
Feeling easily annoyed or irritated	
Temper outbursts that you could not control	
Having urges to beat, injure, or harm someone	
Others: _____	
Phobic Anxiety	
Feeling afraid to go out of your house alone	
Avoiding certain things, places, or activities	
Feeling terrified or panic-stricken	
Others: _____	
Paranoid Ideation	
Feeling that most people cannot be trusted	
Feeling that you are watched or talked about by others	
Feeling that others are to blame for your troubles	
Others: _____	
Psychoticism	
Hearing voices that other people do not hear	

Having thoughts that are not your own	
Having visions or seeing things that other people do not see	
Others: _____	

Global Indices

Global Severity Index (GSI)/ Overall level of distress

Positive Symptom Distress Index (PSDI)/ Intensity of symptoms

Positive Symptom Total (PST)/Total number of symptoms reported

Patient's Responses/Comments

Assessor's Notes

Signatures

Patient's signature

Date

Assessor's signature

Date