Psychosis Spectrum Test

Client Information

Name:

Date of Birth:

Gender:

Address:

Phone Number:

Email Address:

Date of Consultation:

Instructions: Please answer the following questions honestly and to the best of your ability. There are no right or wrong answers. This test aims to assess your risk of experiencing psychosis. Your responses will remain confidential.

1 - Never	2 - Rarely	3 - Sometimes	4 - Often	5 - Very frequently	
☐	☐	☐	☐	☐	1. Have you ever had experiences where you see, hear, or feel things that others around you don't?
☐	☐	☐	☐	☐	2. Do you often find distinguishing between reality and your thoughts or perceptions challenging?
☐	☐	☐	☐	☐	3. Have you ever held beliefs or ideas that seem unusual or irrational to others?

☐	☐	☐	☐	☐	4. Do you frequently experience disorganized or jumbled thinking patterns?
☐	☐	☐	☐	☐	5. Have you noticed a decline in your ability to function effectively in daily activities or maintain relationships?
☐	☐	☐	☐	☐	6. Are you experiencing increased feelings of suspicion or paranoia toward others?
☐	☐	☐	☐	☐	7. Have you ever felt detached from your emotions or experienced a significant decrease in emotional responsiveness?
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☐	☐	☐	☐	☐	9. Have you had significant changes in your sleep patterns or disturbances, such as difficulty falling asleep or frequent nightmares?

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Interpretation of results:

Recommendation: