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310.207.2995

PATIENT INFORMATION
Please use **BLUE** or **BLACK** ink and write **LEGABLY.**
Patient's Name: _____SS#_____ - _____ - _____ Sex: ☐ Male ☐ Female
Date of Birth: _____ Age: _____
Home Address: _____
City, State, Zip: _____
Home Phone: (_____)_____Cell Phone: (_____)_____ Occupation: _____ ☐ Student
Employer (School, if student): _____ School Phone: (_____) _____
School Address:_____
E-mail Address:_____ Fax (_____)_____

SPOUSE'S INFORMATION
Spouse's Name: _____ SS#_____ - _____ - _____ Date of Birth: _____Age: _____
Spouse's Occupation/Employer: _____ Address:_____

RESPONSIBLE PARTY
Responsible Party: _____ SS#_____ - _____ - _____ Date of Birth: _____Age: _____
Home Address: _____
Home Phone: (_____)_____ Occupation:_____
Employer: _____Work Phone: (_____)_____
Employer Address: _____ Driver's License No.:_____
Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

REFERRAL SOURCE
Referral Source _____

Referral Address_____ Phone# _____

Do we have permission to release information to the referring professional when it is appropriate?
☐ Yes ☐ No

FEES CHARGED: Unless other specific arrangements are made I will pay the agreed fee at each session. Payment is required for no-shows or less than a 24 hour notice of cancellation. I understand I am responsible for all charges, including cancellations within less than 24 hours.

Signature of Responsible Party (required): _____

ADULT INTAKE QUESTIONNAIRES

In order for us to be able to fully evaluate you, please fill out the following intake form and questionnaires to the best of your ability. We realize there is a lot of information and you may not remember of have access to all of it; do the best you can.

Main purpose of the consultation: *(Please give a brief summary of the main problems)*

Why did you seek the evaluation at this time? *What are your goals in being here?*

PAST AND PRESENT PSYCHIATRIC MEDICATIONS

We included a detailed list of most psychiatric medication on pages 4-5 to be used as a reference. If you need more room, please attach another sheet.

1. The name of the medication
2. The mg, dose
3. The amount of tablets or mg you took in one day
4. The approximate dates taken - preferably in sequential order
5. Whether the medicine worked well, worked partially, or did not work at all
6. Any side effects or adverse effects from the medication

Date Taken	**Medication** *(Individual or Combinations) Dosage(s) and time(s) taken per day*	**Effectiveness**	**Side-Effects / Problems**
Example: 3/2000 - 12/2005	Example: *Ritalin 5mg BID, Prozac 10mg QAM*	Example: *Improved concentration in morning, still moody*	Example: *Very unfocused and hyperactive in evenings; dry mouth*

MEDICATION REFERENCE LIST

ADD Medications

Adderall / Adderall XR *4 amphetamine salts*	Concerta *methylphenidate*	Cylert *pemoline*	Daytrana *methylphenidate transdermal*
Desoxyn *methamphetamine HCL*	Dexedrine *dextroamphetamine*	Dexedrine Spansules *dextroamphetamine*	Dextrostat *dextroamphetamine*
Focalin *dexmethylphenidate*	Focalin XR *dexmethylphenidate hydrochloride*	Intuniv *guanfacine*	Metadate *methylphenidate*
Metadate CR *methylphenidate hydrochloride*	Methylin *methylphenidate*	Provigil *modafinil*	Ritalin *methylphenidate*
Ritalin LA *methylphenidate*	Ritalin SR *methylphenidate*	Strattera *atomoxetine*	Vyvanse *lisdexamfetamine*

Antidepressants

Anafranil *clomipramine hcl*	Asendin *amoxapine*	Celexa *citalopram*	Cymbalta *duloxetine HCl*
Desyrel *trazodone*	Effexor/Effexor XR *venlafaxine*	Elavil *amitriptyline*	Eldepryl *selegiline HCl*
EMSAM *selegiline transdermal system*	Lexapro *escitalopram*	Ludiomil *maprotiline*	Luvox *fluvoxamine*
Marplan *isocarboxazid*	Nardil *phenelzine*	Norpramin *desipramine*	Pamelor *nortriptyline*
Parnate *tranylcypromine*	Paxil/Paxil CR *paroxetine*	Pristiq *desvenlafaxine extended release*	Prozac *fluoxetine*
Remeron *mirtazapine*	Serzone *nefazodone*	Sinequan *doxepin*	Surmontil *trimipramine*
Tofranil *imipramine*	Vivactil *protripfyline*	Wellbutrin/Wellbutrin SR or XL *bupropion*	Zoloft *sertaline*

Anti-Anxiety Medications

Ativan *lorazepam*	BuSpar *buspirone*	Klonopin *clonazepam*	Librium *chlordiazepoxide*
Serax *oxazepam*	Tranxene *clorazepate*	Valium *diazepam*	Visatril *hydroxyzine*
Xanax *alprazolam*			

Mood Stabilizers

Depakene *valproic acid*	Depakote *divalproex*	Dilantin *phenytoin*	Donnatal *phenobarbital*
Gabitril *tigabine*	Keppra *levetiracetam*	Lamictal *lamotrigine*	Lithium/Eskalith *lithium carbonate*
Lyrica *pregablin*	Neurontin *gabapentin*	Tegretol/Carbatrol Tegretol XR *carbamazepeine*	Trileptal *oxcarbazepine*
Topamax *topiramate*	Zonegran *zonisamide*		

Anti-Tic Hypertensive Medications

Catapres *clonidine*	Inderal *propranolol*	Tenex *guanfacine*	

Anti-Psychotic Medications

Abilify *aripiprazole*	Clozaril *clozapine*	Geodon *ziprasidone HCl*	Haldol *haloperidol*
Invega *paliperidone*	Loxitane *loxapine*	Mellaril *molindone*	Moban *molindone*
Navane *thiothixene*	Orap *pimozide*	Prolixin *fluphenazine*	Risperdal *risperidone*
Serentil *mesoridazine*	Seroquel *quetiapine*	Stelazine *trifluoperazine*	Symbyax *olanzapine/fluoxetine HCl*
Thorazine *chlorpromazine*	Trilafon *perphenazine*	Zydis *olanzapine*	Zyprexa *olanzapine*

Movement Disorders

Artane *trihexyphenidyl*	Benadryl *diphenhydramine*	Cogentin *benztropine*	Symmetrel *amantadine*

Memory / Alzheimer's Medications

Aricept *donepezil HCl*	Exelon *revastigmine tartrate*	Namenda *memantine*	Reminyl - now Razadyne ER *galantamine HBR*

Sleep Aid

Ambien/Ambien CR *zolpidem tartrate*	Dalmane *flurazepam*	Desyrel *trazodone*	Doral *quazepam tablets*
Halcion *triazolam*	Lunesta *zopiclone*	ProSom *estazolam*	Restoril *temazepam*
Rohypnol *flunitrazepam*	Rozerem *ramelteon*	Sonata *zaleplon*	

Weight Loss

Fenfluramine *fenfluramine hydrochloride*	Meridia *sibutramine hydrochloride monohydrate*	Phentermine *phenethylamine*	

Sexual Dysfunction

Cialis *tadalafil*	Levitra *Cardenafil HCl*	Viagra *sildenafil citrate*	

Migraine Medications

Amerge *naratriptan*	Axert *almotriptan malate*	Esgic plus *butalbital / acetaminophen*	Fioricet *butalbital / acetaminophen*
Fiorinal *aspirin / butalbital / caffeine*	Frova *frovatriptan succinate*	Imitrex *sumatriptan succinate*	Maxalt *rizatriptan benzoate*
Replax *eletriptan hydrobromide*	Zomig *zolmitriptan*		

Pain Medications

Avinza *morphine sulfate extended release*	Darvocet *propoxyphene*	Darvon *propoxyphene*	Fentanyl *fentanyl citrate*
Kadian *morphine sulfate extended release*	Oxycontin *oxycodone*	Percocet *oxycodone HCl/APAP CII*	Percodan *aspirin / hydrocodone*
Roxanol *morphine sulfate*	Vicodin *hydrocodone*		

PRIOR ATTEMPTS TO CORRECT PROBLEMS/PRIOR PSYCHIATRIC HISTORY

Please indicate if you have attempted the following treatment:

- ☐ Psychiatrist
- ☐ Neurologist
- ☐ Cardiologist
- ☐ Alternative/Holistic/Naturopathic (include type) _____
- ☐ Therapy (include type and duration) _____
- ☐ Psychiatric Inpatient Hospitalization (if multiple attempts include overall duration) _____
- ☐ Outpatient Treatment Program (if multiple attempts indicate overall duration) _____
- ☐ Other _____

Please list any prior diagnoses: _____

_____

MEDICAL HISTORY

Current medical problems/medications:_____

_____

Current supplements/vitamins/herbs:_____

_____

Past medical problems/medications:_____

_____

Past supplements/vitamins/herbs:_____

_____

Name of Primary Care Physician: _____

Other doctors/clinics seen currently:_____

Allergies/drug intolerances (describe):_____

Date of last physical exam: _____

Present Height _____ *Present Weight* _____ *Present Waist Size*_____

*Date started last menstrual period:*_____

Please indicate if you have a history of the following:

- ☐ Seizure or seizure like activity
- ☐ Periods of spaciness or confusion
- ☐ Concussion
- ☐ Whiplash
- ☐ Loss of consciousness (describe): _____
- ☐ Head trauma (describe, list date or approximate age): _____
- ☐ Stitches on face or head (describe): _____

CURRENT LIFE STRESSES (include anything that is currently stressful for you, examples include relationships, job, school, finances, children):_____
_____
_____

Prenatal and birth events:
Your parents' attitudes toward their pregnancy with you:_____
Pregnancy complications (bleeding, excess vomiting, medication, infections, x-rays, smoking, alcohol/drug use, etc._____
Any birth problems, trauma, forceps or complications?_____

Diet/Exercise History:
Would you consider your diet mostly healthy or unhealthy?_____
Any food allergies/sensitivities? ☐ Yes ☐ No ___ If yes, please list:_____
Are you currently on a restricted diet (i.e. vegetarian, high protein only, etc)?
☐ Yes ☐ No ___ If yes, please list restrictions: _____
Any experience with a gluten free diet? ☐ Yes ☐ No ___ If yes, please list results:_____
Any experience with a casein free diet? ☐ Yes ☐ No ___ If yes, please list results:_____
Caffeine consumption per day (i.e. coffee, soda, tea, chocolate):_____
How many days a week do you eat fruits?_____ vegetables?_____ breakfast?_____
Describe your current bowel function:_____
Describe your current exercise regimen:_____

How many times a day do you eat?_____
What is your typical eating schedule?_____
Do you drink 8 glasses of water per day? ☐ Yes ☐ No
Would you consider yourself to be over or underweight? _____
What is your ideal weight?_____ What is your BMI?_____
How long have you struggled with weight issues?_____
What weight loss measures have you tried?_____

Sleep Behavior:
Any problems falling asleep?_____
Any problems staying asleep?_____
Any problems waking up?_____
On average, how many hours do you sleep per night?_____
Any history of sleepwalking, recurrent dreams, sleep apnea, heavy snoring, or sleep bruxism (grinding your teeth)?_____
_____

School History: Highest Level of Education _____ Last school attended _____
Average grades received _____ Learning strengths _____
Specific learning disabilities _____
Any behavioral problems in school?_____
What have teachers said about you? _____

Employment History: (summarize jobs you've had, list most favorite and least favorite)

_____
_____
_____

Any work-related problems?_____
What would your employers or supervisors say about you?_____

Military History?_____

Ever Any Legal Problems? (including traffic violations)_____
_____

Alcohol and Drug History:
Do you or have you ever experienced withdrawal symptoms from alcohol or drugs?_____
Has anyone told you they thought you had a problem with drugs or alcohol?_____
Have you ever felt guilty about your drug or alcohol use? _____
Have you ever felt annoyed when someone talked to you about your drug or alcohol use? _____
Have you ever used drugs or alcohol first thing in the morning?_____
If you have used or experimented with any of the following, please list the age started and describe how each substance made you feel (i.e. benefits, side effects, or changes to mood).

(C= Current, P= Past)

C	P	
☐	☐	Alcohol (hard liquor, beer, wine) _____
☐	☐	Nicotine (cigarettes, cigars, tobacco chew); indicate use per day (past and present): _____
☐	☐	Marijuana or hash _____
☐	☐	Inhalants (glue, gasoline, cleaning fluids, etc) _____
☐	☐	Cocaine or crack _____
☐	☐	Amphetamines _____
☐	☐	Crank or ice _____
☐	☐	Steroids _____
☐	☐	Opiates (heroin, oxycodone, morphine or other pain killers) _____
☐	☐	Barbiturates _____
☐	☐	Hallucinogens (LSD, mescaline, mushrooms, ecstasy) _____
☐	☐	Prescription tranquilizers or sleeping pills _____
☐	☐	Other: _____

Sexual history: (answer only as much as you feel comfortable)
Age at the time of first sexual experience: _____ Number of sexual partners: _____
Any history of a sexually transmitted disease?_____ History of abortion?_____
History of sexual abuse, molestation or rape?_____
Current sexual problems?_____

Any history of being physically abused? _____
_____

FAMILY HISTORY

Family Structure (who lives in your current household, please list relationship to each):
_____
_____
_____

Current Marital or Relationship Satisfaction_____
_____
_____
_____
_____

History of Past Marriages_____

Significant Developmental Events (include marriages, separations, divorces, deaths, traumatic events, losses, abuse, etc.)_____

_____

Biological Mother's History: ☐ Living; Age ____ ☐ Deceased; Age ____ Cause of death _____
Marriages _____Highest Level of Education: _____Occupation: _____
Learning problems _____ Behavioral/Emotional problems _____
Medical Problems (include heart problems, sudden death, congenital disorders)_____

_____
Has mother ever sought psychiatric treatment? ☐ Yes ☐ No ___ If yes, for what purpose?_____

_____
Patient's mother's alcohol/drug use history_____

_____
Have any of your mother's blood relatives ever had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, or psychiatric hospitalizations?
(specify)_____

_____

Biological Father's History: ☐ Living; Age ____ ☐ Deceased; Age ____ Cause of death _____
Marriages _____Highest Level of Education: _____Occupation: _____
Learning problems _____ Behavior problems _____
Medical Problems (include heart problems, sudden death, congenital disorders)_____

_____
Has father ever sought psychiatric treatment? ☐ Yes ☐ No ___ If yes, for what purpose?_____

_____
Patient's father's alcohol/drug use history_____

_____
Have any of your father's blood relatives ever had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, or psychiatric hospitalizations?
(specify)_____

_____

Patient's siblings (names, ages, problems, strengths, relationship to patient)_____
_____
_____
_____

Patient's children (names, ages, problems, strengths)_____
_____
_____
_____

Cultural/Ethnic Background _____
_____

Describe yourself _____

Describe your strengths _____
_____

Describe your relationships with friends _____
_____

BRAIN SYSTEM CHECKLIST

Please rate yourself on each of the symptoms listed below using the following scale. If possible, to give us the most complete picture, have another person who knows you well (such as a spouse, partner or parent) rate you as well. List other _____

0	1	2	3	4	NA
Never	Rarely	Occasionally	Frequently	Very Frequently	Not Applicable

Other	Self	
____	___	1. Failing to give close attention to details or making careless mistakes
____	___	2. Having trouble sustaining attention in routine situations (e.g., homework, chores, paperwork)
____	___	3. Having trouble listening
____	___	4. Failing to finish things
____	___	5. Having poor organization for time or space (such as a backpack, room, desk, paperwork)
____	___	6. Avoiding, disliking, or being reluctant to engage in tasks that require sustained mental effort
____	___	7. Losing things
____	___	8. Being easily distracted
____	___	9. Being forgetful
____	___	10. Having poor planning skills
____	___	11. Lacking clear goals or forward thinking
____	___	12. Having difficulty expressing feelings
____	___	13. Having difficulty expressing empathy for others
____	___	14. Experiencing excessive daydreaming
____	___	15. Feeling bored
____	___	16. Feeling apathetic or unmotivated
____	___	17. Feeling tired, sluggish or slow moving
____	___	18. Feeling spacey or “in a fog”
____	___	19. Feeling fidgety, restless or trouble sitting still
____	___	20. Having difficulty remaining seated in situations where remaining seated is expected
____	___	21. Running about or climbing excessively in situations in which it is inappropriate
____	___	22. Having difficulty playing quietly
____	___	23. Being always "on the go" or acting as if "driven by a motor"
____	___	24. Talking excessively
____	___	25. Blurting out answers before questions have been completed
____	___	26. Having difficulty waiting.
____	___	27. Interrupting or intruding on others (e.g., butting into conversations or games)
____	___	28. Behaving impulsively (saying or doing things without thinking first)
____	___	29. Worrying excessively or senselessly
____	___	30. Getting upset when things do not go your way
____	___	31. Getting upset when things are out of place
____	___	32. Tending to be oppositional or argumentative
____	___	33. Tending to have repetitive negative thoughts
____	___	34. Tending toward compulsive behaviors (i.e., things you feel you *must* do)
____	___	35. Intensely disliking change
____	___	36. Tending to hold grudges
____	___	37. Having trouble shifting attention from subject to subject
____	___	38. Having trouble shifting behavior from task to task
____	___	39. Having difficulties seeing options in situations

_____ ___40. Tending to hold on to own opinion and not listen to others
_____ ___41. Tending to get locked into a course of action, whether or not it is good
_____ ___42. Needing to have things done a certain way or else becoming very upset
_____ ___43. Others complaining that you worry too much
_____ ___44. Tending to say no without first thinking about the question
_____ ___45. Tending to predict fear
_____ ___46. Experiencing frequent feelings of sadness
_____ ___47. Having feelings of moodiness
_____ ___48. Having feelings of negativity
_____ ___49. Having low energy
_____ ___50. Being irritable
_____ ___51. Having a decreased interest in other people
_____ ___52. Having a decreased interest in things that are usually fun or pleasurable
_____ ___53. Having feelings of hopelessness about the future
_____ ___54. Having feelings of helplessness or powerlessness
_____ ___55. Feeling dissatisfied or bored
_____ ___56. Feeling excessive guilt
_____ ___57. Having suicidal feelings
_____ ___58. Having crying spells
_____ ___59. Having lowered interest in things that are usually considered fun
_____ ___60. Experiencing sleep changes (too much or too little)
_____ ___61. Experiencing appetite changes (too much or too little)
_____ ___62. Having chronic low self-esteem
_____ ___63. Having a negative sensitivity to smells/odors
_____ ___64. Frequently feeling nervous or anxious
_____ ___65. Experiencing panic attacks
_____ ___66. Symptoms of heightened muscle tension (such as headaches, sore muscles, hand tremors, etc.)
_____ ___67. Experiencing periods of a pounding heart, a rapid heart rate, or chest pain
_____ ___68. Experiencing periods of troubled breathing or feeling smothered
_____ ___69. Experiencing periods of dizziness, faintness, or feeling unsteady on your feet
_____ ___70. Feeling nausea or having an upset stomach
_____ ___71. Experiencing periods of sweating, hot flashes, or cold flashes
_____ ___72. Tending to predict the worst
_____ ___73. Having a fear of dying or doing something crazy
_____ ___74. Avoiding places for fear of having an anxiety attack
_____ ___75. Avoiding conflict
_____ ___76. Excessively fearing being judged or scrutinized by others
_____ ___77. Having persistent phobias
_____ ___78. Having low motivation
_____ ___79. Having excessive motivation
_____ ___80. Experiencing tics (either motor or vocal)
_____ ___81. Having poor handwriting
_____ ___82. Being quick to startle
_____ ___83. Having a tendency to freeze in anxiety-provoking situations
_____ ___84. Lacking confidence in own abilities
_____ ___85. Feeling shy or timid
_____ ___86. Being easily embarrassed
_____ ___87. Being sensitive to criticism
_____ ___88. Biting fingernails or picking at skin
_____ ___89. Having a short fuse or experiencing periods of extreme irritability

_____ ___90. Having periods of rage with little provocation
_____ ___91. Often misinterpreting comments as negative when they are not
_____ ___92. Finding that own irritability tends to build, then explodes, then recedes, often being tired after a rage
_____ ___93. Having periods of spaciness and/or confusion
_____ ___94. Experiencing periods of panic and/or fear for no specific reason
_____ ___95. Experiencing visual and/or auditory changes, such as seeing shadows or hearing muffled sounds
_____ ___96. Having frequent periods of *deja vu* (that is, feelings of being somewhere you have never been)
_____ ___97. Being sensitive or mildly paranoid
_____ ___98. Experiencing headaches or abdominal pain of uncertain origin
_____ ___99. Having a history of a head injury or family history of violence or explosiveness
_____ ___100. Having dark thoughts, ones that may involve suicidal or homicidal thoughts
_____ ___101. Experiencing periods of forgetfulness or memory problems

ADULT GENERAL SYMPTOM CHECKLIST

Please rate yourself on each of the symptoms listed below using the following scale. If possible, to give us the most complete picture, have another person who knows you well (such as a spouse, partner or parent) rate you as well. List the other person_____

0	1	2	3	4	NA
Never	Rarely	Occasionally	Frequently	Very Frequently	Not Applicable

Other	Self	
____	___	1. Feeling depressed or being in a sad mood
____	___	2. Having a decreased interest in things that are usually fun, including sex
____	___	3. Experiencing a significant change in weight or appetite, increased or decreased
____	___	4. Having recurrent thoughts of death or suicide
____	___	5. Experiencing sleep changes, such as a lack of sleep or a marked increase in sleep
____	___	6. Feeling physically agitated or of being "slowed down"
____	___	7. Having feelings of low energy or tiredness
____	___	8. Having feelings of worthlessness, helplessness, hopelessness or guilt
____	___	9. Experiencing decreased concentration or memory
____	___	10. Having periods of an elevated, high or irritable mood
____	___	11. Having periods of a very high self-esteem or grandiose thinking
____	___	12. Having periods of decreased need for sleep without feeling tired
____	___	13. Being more talkative than usual or feeling pressure to keep talking
____	___	14. Having racing thoughts or frequently jumping from one subject to another
____	___	15. Being easily distracted by irrelevant things
____	___	16. Having a marked increase in activity level
____	___	17. Excessive involvement in pleasurable activities that have the potential for painful consequences (e.g., spending money, sexual indiscretions, gambling, foolish business ventures)
____	___	18. Experiencing panic attacks, which are periods of intense, unexpected fear or emotional discomfort (list number per month ____)
____	___	19. Having periods of trouble breathing or feeling smothered
____	___	20. Having periods of feeling dizzy, faint or unsteady on your feet
____	___	21. Having periods of heart pounding or rapid heart rate
____	___	22. Having periods of trembling or shaking
____	___	23. Having periods of sweating
____	___	24. Having periods of choking
____	___	25. Having periods of nausea or abdominal discomfort/trouble
____	___	26. Having feelings of a situation "not being real"
____	___	27. Experiencing numbness or tingling sensations
____	___	28. Experiencing hot or cold flashes
____	___	29. Having periods of chest pain or discomfort
____	___	30. Fearing death
____	___	31. Fearing going crazy or doing something out-of-control
____	___	32. Avoiding everyday places for 1) fear of having a panic attack or 2) needing to go with other people in order to feel comfortable
____	___	33. Excessive fear of being judged by others, which causes you to avoid or get anxious in situations
____	___	34. Experiencing persistent, excessive phobia (heights, closed spaces, specific animals, etc.) please list _____

_____ ___ 35. Having recurrent bothersome thoughts, ideas, or images that you try to ignore
_____ ___ 36. Having trouble getting "stuck" on certain thoughts, or having the same thought over and over
_____ ___ 37. Experiencing excessive or senseless worrying
_____ ___ 38. Others complaining that you worry too much or get "stuck" on the same thoughts
_____ ___ 39. Having compulsive behaviors that you must do or else you feel very anxious, such as excessive hand washing, checking locks, or counting or spelling
_____ ___ 40. Needing to have things done a certain way or else you become very upset
_____ ___ 41. Others complaining that you do the same thing over and over to an excessive degree (such as cleaning or checking)
_____ ___ 42. Experiencing recurrent and upsetting thoughts of a past traumatic event (molestation, accident, fire, etc.), please list _____
_____ ___ 43. Experiencing recurrent distressing dreams of a past upsetting event
_____ ___ 44. Having a sense of reliving a past upsetting event
_____ ___ 45. Having a sense of panic or fear of events that resemble an upsetting past event
_____ ___ 46. Spending effort avoiding thoughts or feelings associated with a past trauma
_____ ___ 47. Regularly avoiding activities/situations which cause remembrance of an upsetting event
_____ ___ 48. Being unable to recall an important aspect of a past upsetting event
_____ ___ 49. Having a marked decreased interest in important activities
_____ ___ 50. Feeling detached or distant from others
_____ ___ 51. Feeling numb or restricted in your feelings
_____ ___ 52. Feeling that your future is shortened
_____ ___ 53. Being quick to startle
_____ ___ 54. Feeling like you're always watching for bad things to happen
_____ ___ 55. Experiencing a marked physical response to events that remind you of a past upsetting event (e.g., sweating, increased pulse, etc.) when getting in a car if you had been in a car accident
_____ ___ 56. Being markedly more irritable or experiencing anger outbursts
_____ ___ 57. Having unrealistic or excessive worry in at least a couple areas of your life
_____ ___ 58. Trembling, twitching, or feeling shaky
_____ ___ 59. Experiencing muscle tension, aches, or soreness
_____ ___ 60. Having feelings of restlessness
_____ ___ 61. Becoming easily fatigued
_____ ___ 62. Experiencing shortness of breath or feeling smothered
_____ ___ 63. Experiencing a pounding or racing heartbeat
_____ ___ 64. Sweating or having cold, clammy hands
_____ ___ 65. Experiencing dry mouth
_____ ___ 66. Experiencing dizziness or lightheadedness
_____ ___ 67. Having nausea, diarrhea or other abdominal distress
_____ ___ 68. Having hot or cold flashes
_____ ___ 69. Having to urinate frequently
_____ ___ 70. Having trouble swallowing or feeling a "lump in your throat"
_____ ___ 71. Feeling keyed up or on edge
_____ ___ 72. Being quick to startle or feeling jumpy
_____ ___ 73. Finding it difficult to concentrate, or having your "mind go blank"
_____ ___ 74. Having trouble falling or staying asleep
_____ ___ 75. Experiencing irritability
_____ ___ 76. Having trouble sustaining attention or being easily distracted
_____ ___ 77. Experiencing difficulty completing projects
_____ ___ 78. Feeling overwhelmed by the tasks of everyday living
_____ ___ 79. Having trouble maintaining an organized work or living area
_____ ___ 80. Being inconsistent in work performance

_____ ___ 81. Lacking in attention to detail
_____ ___ 82. Making decisions impulsively
_____ ___ 83. Having difficulty delaying what you want, having to have your needs met immediately
_____ ___ 84. Feeling restless and/or fidgety
_____ ___ 85. Making comments to others without considering their impact
_____ ___ 86. Being impatient and/or easily frustrated
_____ ___ 87. Experiencing frequent traffic violations or near accidents
_____ ___ 88. Refusing to maintain body weight above a level that most people consider healthy
_____ ___ 89. Intensely fearing gaining weight or becoming fat even though underweight
_____ ___ 90. Having feelings of being fat, even though you're underweight
_____ ___ 91. Experiencing recurrent episodes of binge eating large amounts of food
_____ ___ 92. Feeling of lack of control over eating behavior
_____ ___ 93. Engaging in regular activities to purge binges, such as self-induced vomiting, laxatives, diuretics, strict dieting, or strenuous exercise
_____ ___ 94. Being overly concerned with body shape and/or weight
_____ ___ 95a. Experiencing involuntary physical movements and/or motor tics (such as eye blinking, shoulder shrugging, head jerking or picking). How long have tics been present?_____ How often?_____
Please describe_____
_____ ____ 95b. Experiencing involuntary vocal sounds or verbal tics (such as coughing, puffing, blowing, whistling, or swearing).
How long have tics been present?_____ How often?_____
Please describe:_____
_____ ___ 96. Having delusional or bizarre thoughts (thoughts you know others would think are false)
_____ ___ 97. Seeing objects, shadows or movements that are not real
_____ ___ 98. Hearing voices or sounds that are not real
_____ ___ 99. Experiencing periods of time where your thoughts or speech were disjointed or didn't make sense to you or others
_____ ___ 100. Feeling socially isolated or withdrawn
_____ ___ 101. Having a severely impaired ability to function at home or at work
_____ ___ 102. Behaving peculiarly
_____ ___ 103. Lacking personal hygiene or grooming
_____ ___ 104. Being in an inappropriate mood for a given situation (e.g., laughing at sad events)
_____ ___ 105. Having a marked lack of initiative
_____ ___ 106. Having frequent feelings that someone or something is out to hurt you or discredit you
_____ ___ 107. Snoring loudly (or others complaining about your snoring)
_____ ___ 108. Others saying that you stop breathing when you sleep
_____ ___ 109. Feeling fatigued or tired during the day
_____ ___ 110. Often feeling cold when others feel fine or they are warm
_____ ___ 111. Often feeling warm when others feel fine or they are cold
_____ ___ 112. Having problems with brittle or dry hair
_____ ___ 113. Having problems with dry skin
_____ ___ 114. Having problems with sweating
_____ ___ 115. Having problems with chronic anxiety or tension
_____ ___ 116. Having impairment in communication as manifested by at least one of the following (please circle all that apply):

- A delay in or total lack of the development of spoken language (not accompanied by an attempt to compensate);
- In individuals with adequate speech, having a marked impairment in the ability to initiate or sustain a conversation with others;

- The repetitive use of language, or the use of odd language;
- A lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level.

____ ___ 117. Having an impairment in social interaction, with at least two of the following (please circle all that apply):

- A marked impairment in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction;
- A failure to develop peer relationships appropriate to developmental level;
- A lack of spontaneously seeking to share enjoyment, interests, or achievements with other people (e.g., by a lack of showing, bringing, or pointing out objects of interest);
- A lack of social or emotional reciprocity.

____ ___ 118. Having repetitive patterns of behavior, interests, and activities, as manifested by at least one of the following (please circle all that apply):

- A preoccupation with an area that is abnormal either in intensity or focus;
- A rigid adherence to specific, nonfunctional routines or rituals;
- Repetitive motor mannerisms (e.g., hand or finger flapping or twisting, or complex whole-body movements);
- A persistent preoccupation with parts of objects.

☐ Health
☐ Problems
☐ Checklist
☑

John A. Schinka, Ph.D.

Name _____ Age _____ Date _____

Occupation _____ Marital Status _____

DIRECTIONS

On the following pages you will find a list of common health problems and health practices. This list surveys symptoms, habits, and health history. Read the list carefully and make a check (✓) next to each item that applies to you. Do your best to read each item carefully and answer as honestly as you can.

If you are having health problems which are not listed on the following pages, please write them on the last page in the space provided. On the last page there are also questions about current illnesses, medications, and the names of doctors now treating you. Answer these questions in the space provided.

EXAMPLE

72 ✓ difficulty in taking a full breath

73 _____ wheezy or noisy breathing

74 ✓ frequent cough

Your answers will only be discussed with your doctor or counselor.

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Check all items which apply

GEN/12

1 ☐ poor health
2 ☐ recent change in health
3 ☐ always feel sick
4 ☐ trouble sleeping
5 ☐ trouble falling asleep
6 ☐ feeling weak all over
7 ☐ get tired easily
8 ☐ loss of strength
9 ☐ get sick often
10 ☐ loss of appetite
11 ☐ weight has changed
12 ☐ often have fever or chills

DERM/10

13 ☐ texture of skin has changed
14 ☐ itching
15 ☐ have rashes
16 ☐ skin drying out
17 ☐ new warts, moles, or other growth on skin
18 ☐ have areas of discolored skin
19 ☐ skin breaking out in blemishes
20 ☐ loss of hair
21 ☐ change in appearance of fingernails
22 ☐ change in texture of fingernails

VIS/14

23 ☐ change in vision
24 ☐ double vision
25 ☐ trouble seeing at night
26 ☐ trouble seeing to the left or right
27 ☐ blurred vision
28 ☐ blind spots in vision
29 ☐ flashing lights in vision
30 ☐ inflamed eyes
31 ☐ pain in eyes
32 ☐ discharge from eyes
33 ☐ itching eyes
34 ☐ swollen eyelids
35 ☐ soreness around eyes
36 ☐ often have tears in eyes

AUD/OLF/14

37 ☐ loss of hearing
38 ☐ ringing in ears
39 ☐ strange sounds in ears
40 ☐ change in hearing in one ear
41 ☐ earaches
42 ☐ discharge from ear
43 ☐ loss of sense of smell
44 ☐ change in sense of smell
45 ☐ smell bad odors
46 ☐ runny nose
47 ☐ stuffed up nose
48 ☐ nosebleeds
49 ☐ sinus problems
50 ☐ pain around nose and sinuses

M/T/N/18

51 ☐ sore tongue
52 ☐ sore gums
53 ☐ swollen lips
54 ☐ toothache
55 ☐ sores in or around mouth
56 ☐ sore throat
57 ☐ hoarseness
58 ☐ change in voice
59 ☐ difficulty swallowing
60 ☐ dry mouth
61 ☐ too much saliva
62 ☐ change in sense of taste
63 ☐ loss of sense of taste
64 ☐ losing teeth
65 ☐ stiff neck
66 ☐ swollen glands in neck
67 ☐ neck is sore and tender
68 ☐ lump in neck

CARD/PUL/18

69 ☐ pain in chest
70 ☐ pain when taking a breath
71 ☐ difficulty in breathing
72 ☐ difficulty in taking a full breath
73 ☐ wheezy or noisy breathing
74 ☐ frequent cough
75 ☐ coughing spells
76 ☐ cough up blood or mucus
77 ☐ cough up mucus with bad odor
78 ☐ cough up foamy mucus
79 ☐ difficulty breathing during work or exercise
80 ☐ breathing problems when lying down
81 ☐ frequent colds
82 ☐ frequently aware of heartbeat
83 ☐ heartbeat seems irregular
84 ☐ lips or fingernails turn blue
85 ☐ swelling of legs or ankles
86 ☐ high blood pressure

Continued on next page →

Check all items which apply

GI/26

87 ☐ frequent nausea or upset stomach
88 ☐ heartburn
89 ☐ burning in back of throat
90 ☐ stomach always feels full
91 ☐ frequently burp or belch
92 ☐ have a lot of gas
93 ☐ difficulty swallowing food
94 ☐ difficulty eating meat
95 ☐ frequent vomiting
96 ☐ sudden and forceful vomiting
97 ☐ vomiting blood
98 ☐ vomiting undigested food
99 ☐ stomach pain
100 ☐ frequent stomach cramps
101 ☐ change in bowel movements
102 ☐ diarrhea or loose stools
103 ☐ constipation
104 ☐ frequent use of laxatives
105 ☐ often use medicine to settle stomach
106 ☐ bowel movement is bloody
107 ☐ bowel movement is unusual color
108 ☐ painful bowel movements
109 ☐ pain in rectum
110 ☐ hemorrhoids or piles
111 ☐ unable to finish bowel movement
112 ☐ rectum itches

END/HEM/12

113 ☐ bruise or bleed easily
114 ☐ have many bruises
115 ☐ gums bleed after brushing teeth
116 ☐ skin heals slowly
117 ☐ increased appetite
118 ☐ often thirsty
119 ☐ discomfort with heat or cold
120 ☐ excessive sweating
121 ☐ change in size of head, hands, or feet
122 ☐ pale or yellow skin
123 ☐ change in amount of body hair
124 ☐ change in texture of hair

ORTHO/10

125 ☐ bone pain
126 ☐ joint pain
127 ☐ redness in joints
128 ☐ stiffness in joints
129 ☐ fingers becoming crooked
130 ☐ muscle pain
131 ☐ muscle cramps
132 ☐ change in posture
133 ☐ back pain
134 ☐ frequent back problems

NEURO/26

135 ☐ muscle weakness
136 ☐ tics or twitching muscles
137 ☐ muscle spasms
138 ☐ trouble walking
139 ☐ balance problems
140 ☐ tremors or shakiness
141 ☐ problems with dropping things
142 ☐ trouble walking up stairs
143 ☐ numbness in arms or legs
144 ☐ tingling or burning skin
145 ☐ loss of feeling on skin
146 ☐ loss of sense of touch
147 ☐ blackouts or fainting spells
148 ☐ seizures or fits
149 ☐ headaches
150 ☐ having trouble keeping track of time
151 ☐ forgetting things
152 ☐ having memory problems
153 ☐ getting lost while driving
154 ☐ hearing unusual sounds or voices
155 ☐ seeing unusual things
156 ☐ having strange feelings
157 ☐ getting confused
158 ☐ having trouble concentrating
159 ☐ having trouble reading or writing
160 ☐ having problems following a conversation

GU-MEN/16 —MEN ONLY—

161 ☐ frequent urination
162 ☐ blood in urine
163 ☐ trouble starting urination
164 ☐ change in the force of urination
165 ☐ trouble stopping urination
166 ☐ sudden and urgent need to urinate
167 ☐ lose or leak urine
168 ☐ pain or burning on urination
169 ☐ change in color of urine
170 ☐ change in odor of urine
171 ☐ discharge from sexual organ
172 ☐ sores in area of sex organ or groin
173 ☐ pain or swelling in area of groin
174 ☐ change in size of testicles
175 ☐ pain during sexual intercourse
176 ☐ change in sexual performance

Continued on next page →

Check all items that apply

GU-WOMEN/22 —WOMEN ONLY—

177 ☐ frequent urination
178 ☐ blood in urine
179 ☐ trouble stopping urination
180 ☐ pain or burning on urination
181 ☐ lose or leak urine
182 ☐ sudden and urgent need to urinate
183 ☐ change in color or odor of urine
184 ☐ vaginal discharge
185 ☐ menstrual periods have stopped
186 ☐ painful menstrual periods
187 ☐ change in menstrual flow
188 ☐ irregular menstrual periods
189 ☐ sores in area of vagina
190 ☐ pain or swelling in area of vagina
191 ☐ discharge from breast
192 ☐ pain or tenderness in breast
193 ☐ lumps or masses in breast
194 ☐ change in size of breasts
195 ☐ pain during sexual intercourse
196 ☐ change in sexual performance
197 ☐ change of life
198 ☐ hot flashes

HAB/30

199 ☐ rarely exercise
200 ☐ have a regular exercise plan
201 ☐ exercise on weekends
202 ☐ eat a balanced diet
203 ☐ have a poor diet
204 ☐ eat three meals a day
205 ☐ eat at irregular times
206 ☐ take vitamins
207 ☐ always see doctor for yearly checkup
208 ☐ have had checkup in last year
209 ☐ have not seen a doctor for many years
210 ☐ am currently being treated by physician
211 ☐ always have regular dental checkups
212 ☐ have not seen dentist in last year
213 ☐ am taking medication prescribed by my doctor
214 ☐ often use medicine like aspirin or laxatives
215 ☐ do not drink alcohol
216 ☐ have alcoholic drink a few times a week
217 ☐ have alcoholic drink every day
218 ☐ have several alcoholic drinks every day
219 ☐ have a problem with alcohol
220 ☐ have had a problem with alcohol in the past
221 ☐ do not smoke cigarettes
222 ☐ smoke less than a pack of cigarettes a day
223 ☐ smoke a pack of cigarettes every day
224 ☐ have smoked for less than five years
225 ☐ have smoked for more than five years
226 ☐ work with chemicals or solvents
227 ☐ work with fertilizers or weedkillers
228 ☐ work with paint or glue

HX/8

229 ☐ history of head injury
230 ☐ history of heart attack
231 ☐ history of stroke
232 ☐ history of hypertension
233 ☐ history of diabetes
234 ☐ history of seizure disorder or epilepsy
235 ☐ history of cancer
236 ☐ hospitalization in last year

List any other health problem you might have:

List all medications that you are now taking:

List the names of the doctors treating you and the illnesses you are being treated for:

Doctor	Illness

☐ Personal
☐ Problems
☐ Checklist™
☐ for Adults
☑

John A. Schinka, Ph.D.

Name _____ Age _____

Sex _____ Marital Status _____ Date _____

DIRECTIONS

On the following pages you will find a list of problems which people commonly face. This list surveys work, family, school, attitudes, and other problems of everyday life.

Read the list carefully and make a check (✓) next to each problem that you are now having. Circle those problems which you feel are the worst or cause you the most trouble at this time. Remember that there are no correct or incorrect answers. Do your best to answer each item on the list as honestly as you can.

EXAMPLE

43 ✓ having arguments on the job

44 ___ working too many hours

45 ___ job creating health problems

If you are having problems which are not listed on the following pages, please write them on the bottom of the last page. Your answers will only be discussed with your doctor or counselor.

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Check all problems which trouble you. Circle the most important.

SOC/18

1 ☐ not getting along with other people
2 ☐ being criticized by others
3 ☐ not fitting in with peers
4 ☐ feeling uncomfortable in social settings
5 ☐ acting rude or overbearing
6 ☐ acting in an immature way
7 ☐ being suspicious of others
8 ☐ being shy
9 ☐ not having close friends
10 ☐ not having anyone to share interests with
11 ☐ feeling lonely
12 ☐ being unpopular
13 ☐ being uncomfortable when talking to people
14 ☐ feeling inferior
15 ☐ feeling like people are against me
16 ☐ being embarrassed by family background
17 ☐ being let down by friends
18 ☐ feeling different from everyone else

APP/12

19 ☐ being overweight
20 ☐ being too short or too tall
21 ☐ having physical handicap
22 ☐ being too thin
23 ☐ looking too old
24 ☐ having unattractive face
25 ☐ being clumsy and awkward
26 ☐ not being clean and well-groomed
27 ☐ not having suitable clothes
28 ☐ being noticed for physical appearance
29 ☐ having scars
30 ☐ having facial blemishes

VOC/18

31 ☐ not having a job
32 ☐ job not paying enough
33 ☐ disliking type of job
34 ☐ job being dirty
35 ☐ disliking fellow employees
36 ☐ being disliked by co-workers
37 ☐ being afraid of failing on the job
38 ☐ being afraid of being fired or laid off
39 ☐ working in unsafe conditions
40 ☐ friends or relatives criticizing job
41 ☐ lacking supervision on job
42 ☐ boss being critical or unfair
43 ☐ having arguments on the job
44 ☐ working too many hours
45 ☐ job creating health problems
46 ☐ job having no future
47 ☐ needing more education to succeed in job
48 ☐ being bored on job

FAM/HOM/34

49 ☐ children misbehaving
50 ☐ disagreeing on how to raise children
51 ☐ child or spouse having medical problem
52 ☐ child or spouse having emotional problem
53 ☐ spouse having problem with drugs or alcohol
54 ☐ having problems with in-laws
55 ☐ having problems with parents
56 ☐ being separated or divorced from spouse
57 ☐ having constant arguments with spouse
58 ☐ parents being separated or divorced
59 ☐ parents constantly arguing
60 ☐ wanting to have children
61 ☐ not wanting to have a child or more children
62 ☐ parents being too strict
63 ☐ parents interfering with decisions
64 ☐ spouse having different interests
65 ☐ spouse having different background
66 ☐ spouse being unfaithful
67 ☐ having sexual problems in marriage
68 ☐ not being understood by spouse
69 ☐ being unfaithful to spouse
70 ☐ having too much contact with relatives
71 ☐ spouse working too many hours on job
72 ☐ arguing with spouse over money
73 ☐ arguing with spouse over household chores
74 ☐ house or apartment being too small
75 ☐ house or apartment needing repairs
76 ☐ having problems with landlord
77 ☐ not getting along with neighbors
78 ☐ not having any privacy at home
79 ☐ not being able to afford living alone
80 ☐ living under unsanitary or dirty conditions
81 ☐ children leaving home
82 ☐ living in dangerous neighborhood

Continue on next page ►

Check all problems which trouble you. Circle the most important.

SCH/12

83 ☐ getting bad grades
84 ☐ not getting along with teachers
85 ☐ deciding on the right course of studies
86 ☐ not having good study habits
87 ☐ not having a good place to study
88 ☐ taking the wrong courses
89 ☐ not understanding class material
90 ☐ not getting along with other students
91 ☐ feeling out of place in school
92 ☐ feeling education is a waste of time
93 ☐ having a language problem in school
94 ☐ being in the wrong school

FIN/12

95 ☐ budgeting money
96 ☐ not making enough money
97 ☐ not having a steady income
98 ☐ having to spend savings
99 ☐ having unpaid bills
100 ☐ wasting money
101 ☐ depending on others for financial support
102 ☐ lending money to friends or relatives
103 ☐ not being able to pay medical bills
104 ☐ spouse being careless with money
105 ☐ not having enough money for education
106 ☐ dealing with bill collectors

REL/14

107 ☐ feeling guilty about religion
108 ☐ not having any religious beliefs
109 ☐ arguing about religion
110 ☐ being confused about religious beliefs
111 ☐ not having good philosophy of life
112 ☐ failing in religious beliefs
113 ☐ arguing with spouse about religion
114 ☐ not being able to get to church
115 ☐ feeling abandoned by God
116 ☐ work interfering with religious practices
117 ☐ being upset by religious beliefs of others
118 ☐ worrying about being accepted by God
119 ☐ being rejected by church
120 ☐ failing to support church

EMOT/20

121 ☐ feeling anxious or uptight
122 ☐ being afraid of things
123 ☐ having the same thought over and over again
124 ☐ being tired and having no energy
125 ☐ feeling depressed or sad
126 ☐ having trouble concentrating
127 ☐ not remembering things
128 ☐ getting too emotional
129 ☐ feeling guilty
130 ☐ worrying about diseases or illness
131 ☐ being afraid of hurting self
132 ☐ feeling things are unreal
133 ☐ crying without good reason
134 ☐ worrying about having a nervous breakdown
135 ☐ not being able to stop worrying
136 ☐ not being able to relax
137 ☐ being unhappy all the time
138 ☐ not having any enjoyment in life
139 ☐ being influenced by others
140 ☐ behaving in strange ways

SEX/14

141 ☐ being uncomfortable with opposite sex
142 ☐ being afraid of sexual diseases
143 ☐ having a sexual disease
144 ☐ being gay
145 ☐ worrying about sexual performance
146 ☐ not knowing enough about sex
147 ☐ not having someone to talk to about sex
148 ☐ having problems with sexual relationship
149 ☐ having unsatisfactory sexual relationship
150 ☐ thinking about sex too often
151 ☐ disliking sex
152 ☐ being troubled by sexual attitudes of others
153 ☐ being troubled by unusual sexual behavior
154 ☐ being sexually underdeveloped

Continue on next page ►

Check all problems which trouble you. Circle the most important.

LEG/10

155 ☐ needing legal advice
156 ☐ being sued
157 ☐ not having retirement funds
158 ☐ being someone's guardian
159 ☐ being on parole
160 ☐ being legally disowned by family
161 ☐ not receiving child support
162 ☐ not receiving alimony
163 ☐ having legal problem with neighbors
164 ☐ facing criminal charges

HEA/HAB/20

165 ☐ being physically hurt or abused
166 ☐ losing temper and hurting someone
167 ☐ having thoughts of suicide
168 ☐ having a car accident
169 ☐ being attacked by an animal
170 ☐ smoking too many cigarettes
171 ☐ using drugs or alcohol
172 ☐ not getting enough exercise
173 ☐ having poor sleeping habits
174 ☐ eating too much
175 ☐ having physical disability
176 ☐ having chronic illness
177 ☐ having recurring health problems
178 ☐ having many health problems
179 ☐ being unhappy with medical care
180 ☐ watching too much television
181 ☐ not having any hobbies
182 ☐ needing a vacation
183 ☐ having poor eating habits
184 ☐ not making time for leisure activities

ATT/12

185 ☐ having a poor attitude about everything
186 ☐ not having any interest in things
187 ☐ having a recent change in attitude
188 ☐ holding opinions too strongly
189 ☐ having no opinions about anything
190 ☐ having different opinions than others
191 ☐ not understanding attitudes of others
192 ☐ having problems with attitudes about religion
193 ☐ having problems with opinions about politics
194 ☐ having a poor attitude toward work
195 ☐ having a poor attitude toward family
196 ☐ having a poor attitude toward self

CRIS/12

197 ☐ friend or family member committing suicide
198 ☐ friend or family member having serious illness
199 ☐ friend or family member getting a divorce
200 ☐ friend or family member dying
201 ☐ pet dying
202 ☐ losing something valuable
203 ☐ friend or family member attempting suicide
204 ☐ friend or family member losing job
205 ☐ friend or family member being emotionally upset
206 ☐ being robbed
207 ☐ child running away from home
208 ☐ losing job

List any other problems you might have.