STRUCTURED CLINICAL INTERVIEW QUESTIONNAIRE

Private and Confidential Information for Professional Use Only

Current Revision: August 20, 2004

Directions: This questionnaire is designed to provide me with current and past information important to your assessment and treatment. It is very important that you complete it fully, but *you are free NOT to disclose information you do not wish to.*
Put N/A in response to all items that do not apply to you.

I. IDENTIFYING INFORMATION

Your full name: _____ Tel #: _____
Your full address: _____ e-mail: _____
_____
_____
Your age: _____ Your date of birth: _____ Your SSN: _____

You are: _____ married
_____ married but separated
_____ divorced
_____ remarried
_____ widowed
_____ single (never married)

date of marriage: _____
date of separation: _____
date of divorce: _____
date of remarriage: _____
date spouse died: _____

If married, your spouse's name, age, occupation?
_____
_____
_____

Your race/ethnicity: ____ Caucasian-American ____ Hispanic-American ____ Asian-American
____ African-American ____ Other: _____

Gender: ___ male ___ female Where born? _____ Raised? _____

What is your primary (i.e., first-learned or best-known) language? _____

List your children, from youngest to oldest:

Name	Male or Female?	Age	Natural, adopted, or step?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

How many years of schooling have you completed? *(Completed high school equals 12 years. Add any additional schooling years e.g., college, technical school, apprenticeships, etc.)* _____ total years

Degree(s)/Certification(s) achieved?
_____ None
_____ High School
_____ Technical School
_____ other (e.g., M.D., J.D.): _____
_____ College (BA/BS)
_____ Master's degree (MA/MS)
_____ Ph.D

You are: *(check all that apply)*

_____ employed
for how long? _____ part,or full time? _____
by whom? _____
type of work? _____

_____ unemployed
since when? _____
type of work done most recently? _____
reason for leaving: _____

_____ disabled
type of disability? _____
_____
for how long? _____

_____ homemaker

_____ student
currently: __ freshman __ sophomore __ junior __ senior
where? _____

Who has referred you? (check all that apply): ___ self ___ physician ___ attorney ___ other

Name and address of referring person: _____
_____
_____

Are you <u>currently</u> involved in any litigation or legal procedings? **___ yes ___ no**
Explain (*what type of litigation, for what reasons, etc*.): _____
_____

If so, what is your attorney's name and address? _____
_____
_____

Telephone number: _____ Fax number: _____

II. CHIEF COMPLAINT/REASON FOR REFERRAL

What is the MAIN DIFFICULTY (e.g., disturbing/distressing thoughts, disturbing/distressing feelings, disturbing/distressing behaviors) you are having, for which you hope to find psychological assistance?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

In what ways (specifically) do your main difficulties INTERFERE SIGNIFICANTLY with your life/activities?

_____

_____

_____

_____

_____

_____

_____

III. HISTORY OF THE PRESENTING PROBLEM(S)/CHIEF COMPLAINT(S)

How and when did you begin to experience the difficulties you outlined on the preceding page? Please outline EACH problem in terms of **how and when it began**. Please be as specific as possible.

Clinician's Notes: _____

IV. SIGNIFICANT CONCERNS CHECKLIST

Please place a check next to each of the following items as they apply to you; use the following scale:

1	2	3	4	5
Not at all	A little	Moderately	Quite a bit	Extremely

		1	2	3	4	5
1.	Academic/job performance too low, - or - can't seem to work/study effectively					
2.	Cannot seem to budget my time/money/organization					
3.	Having difficulty with learning math, foreign language, spelling, writing, etc.					
4.	Concerned about my drinking/smoking/drug use					
5.	Difficulty concentrating, focusing, and/or remembering things					
6.	Obsessive or repetitive thoughts/images/impulses that are distressing					
7.	Feel very anxious in social situations					
8.	Have panic/anxiety attacks, or have fears that seem unrealistic/excessive					
9.	Distressing behaviors or rituals I cannot control, or that take up excessive time					
10.	Anxious/worried/tense about everything most of the time					
11.	Can't seem to get over what has happened					
12.	Have periods of confusion, with one or more odd/strange experiences (e.g. memory lapses, feeling unreal, "visions," noises/voices in my head, etc.)					
13.	Urges to throw, break or smash things					
14.	Feel intense dislike for some people or someone					
15.	Feel empty inside, or often don't know who I am					
16.	Impulsive behavior (e.g., suicide attempts, "one night stands," drug binges, gambling)					
17.	Patterns of intense, stormy relationships and/or extreme behavior in relationships					
18.	Feel (or have felt) frightened by the idea of someone leaving or abandoning me					
19.	Difficulties related to my weight/physical appearance and/or my eating habits					
20.	Confused about questions of morals/religion/spirituality					
21.	Concerned with sexual functioning/identity/thoughts/feelings/behaviors					
22.	Have difficulty trusting other people					
23.	Can't stand up for myself or assert myself					
24.	Feel lonely, or feel that others do not seem to really care about me					
25.	Low self-esteem and/or worry about what others think of me					
26.	Not interested in activities/relationships that usually (or used to) interest me					
27.	Worry about my physical health					
28.	Feel depressed or sad to the point that it's interfering with my life/activities					
29.	Feel tired, dizzy, and/or weak					
30.	Feel that others do not understand me or recognize my talents/contributions					
31.	Feel that others have wronged me, are out to get me, or trying to bring me down					
32.	Have odd, strange, or unusual experiences that others might not believe					
33.	Feeling as if my thoughts are not my own, or that others can hear/know them					
34.	Urges to beat, injure, or harm someone					
35.	Periods of feeling "revved up" (e.g., little need for sleep, excessive talking, racing thoughts, impulsive or unwise behaviors) that feel out of control or that annoy others					
36.	Easily annoyed or irritated – or – experiencing dramatic "mood swings"					
37.	Thoughts or feelings about ending my life					
38.	Feeling hopeless about the future					
39.	Thoughts of death or dying					
40.	Feel that nothing I do seems meaningful or important					
41.	Problems with sleeping – or – Decreased need for sleep					
42.	Have trouble making decisions and/or can't think clearly					

V. PSYCHIATRIC/PSYCHOLOGICAL HISTORY

Write **TRUE** or **FALSE** next to each of the following:

_____ I have trouble falling asleep. *(initial insomnia)*
_____ I have trouble staying asleep (repeated waking in the middle of the night). *(middle insomnia)*
_____ I wake up early and cannot go back to sleep. *(terminal insomnia)*
_____ I have trouble getting out of bed, and/or I sleep much more than usual. *(hypersomnia)*
_____ I only rarely seem to feel fully refreshed by a night's sleep.
_____ I have nightmares or bad dreams.
_____ I often feel tired, wishing I could go to sleep, during the day.
_____ I often experience burning/pain of the eyes, or puffiness under my eyes.
_____ I am worried about how I seem to have difficulty finding words.
_____ I have difficutly concentrating or staying focused on activities
_____ I seem to crave high-carbohydrate foods (e.g., bread, snack chips/crackers, sugary snacks)
_____ I seem to be unusually cranky or irritable

For each of the following, CIRCLE one or more of "Now", "Past", or "Never" as each item applies to you:

Now Past Never anxiety, worry, tension, etc. that is/was pervasive, *or* that you did not know why they were occurring, *or* that you could not manage
First occurred when? _____ *Last occurred when?* _____

Now Past Never unusual or very distressing fears (*including* "anxiety attacks" or "panic attacks")
First occurred when? _____ *Last occurred when?* _____

Now Past Never obsessive or repetitive *thoughts or images* you could not ignore, or that distressed you in any way
First occurred when? _____ *Last occurred when?* _____

Now Past Never repetitive *behaviors or rituals* that you felt compelled to perform or do
First occurred when? _____ *Last occurred when?* _____

Now Past Never unusual, distressing, uncomfortable, or painful practices or concerns about your sexuality or about anything relating to *sexuality*
First occurred when? _____ *Last occurred when?* _____

Now Past Never persistent headaches, backaches, constipation/stomach upset (*circle one or more*)
explain briefly: _____
_____

Now Past Never strange or unusual physical dysfunctions or pain that doctors could not find a reason for, or for which many different explanations have been offered, but for which little relief has been found

Now Past Never distressing memories, "flashbacks," or dreams of unpleasant events
First occurred when? _____ *Last occurred when?* _____
explain briefly: _____
_____

Now Past Never memory difficulties of any kind
explain briefly: _____
_____

Now Past Never unusual, distressing, or dangerous eating/dieting/body-image concerns/behaviors
explain briefly: _____
_____

Have you ever had periods of days, weeks, or months during which you had ***three or more*** of the following within the same time period? **___ yes ___ no**

*If YES, **check** all that have occurred in the most recent such time period..*

___ unusually FANTASTIC mood
___ unusual irritability/anger (*4)
___ "racing" thoughts
___ extremely talkative, couldn't stop
___ acted impulsively *or* made unwise choices (e.g., spending sprees, unwise sexual behavior)
___ extremely GREAT feelings about yourself & abilities
___ extremely ("BOUNDLESS") high energy/motivation
___ able to go a day or more without sleep & without fatigue
___ felt restless, agitated, excitable, couldn't sit still
___ found it difficult to focus or concentrate on any one thing, *or* left projects unfinished

- *Are you experiencing one of these periods **now**?* _____ *Since when?* _____
- W*hen was the **first** of these episodes?* _____
- *Have you ever had an episode that lasted **four or more days**?* _____
- *Have you ever had an episode that lasted **seven or more days**?* _____
- *How **many** of these episodes have you ever had?* _____

Have any of these episodes resulted in any of the following (check any that apply)?
___ job problems ___ school problems ___ relationship problems ___ legal problems

At their worst, how severe have these problems been? ___ mild ___ moderate ___ severe

Have you ever had periods of days, weeks, or even months, during which you had **three or more** of the following at the same time most of the day, nearly every day? **___ yes ___ no**

*If YES, then **check** all that you experienced during the most recent of these time periods.*

___ depressed, "blue", or sad mood
___ *decreased* appetite and/or significant *weight loss*
___ difficulty falling asleep and/or waking in the night with difficulty getting back to sleep
___ "slowed down", dragging feet, feel unable to move, think, talk, or react quickly *
___ general fatigue or loss of energy *
___ generally feel worse in the morning, and feel somewhat better in the evening
___ unable to enjoy things like you normally do
___ *increased* appetite and/or significant *weight gain*
___ sleep all night & sleeping too much and/or taking naps, feel you can't get enough sleep
___*
___*
___ generally feel worse in the evenings, and feel somewhat better in the mornings
___ fidgeting, pacing, restlessness, "on edge", agitated
___ feelings of worthlessness and/or feeling very guilty (not about feeling sick or down)
___ diminished ability to concentrate, to think clearly, to make decisions
___ recurrent thoughts of death, of suicide, or attempts at suicide
___ constipation or other stomach/bowel/digestive problems
___ diminished sexual interest or activity
___ heavy, lead-like feeling in the arms and/or legs
___ wake too early in the morning (e.g., hour[s] before alarm clock) and cannot fall asleep again
___ couldn't feel happy or laugh even in response to expectably pleasant or funny events

- *Are you experiencing one of these periods **now, or recently**?* _____
- W*hen was the **first** (or only, if that is the case) one?* _____
- *How long did it last?* _____
- *Have any of these periods lasted for **more than two weeks**?* _____
- *How many of these periods have you ever had?* _____
- *When did the **most recent period** begin (what month of what year)?* _____
- *How long has it lasted/did it last (in hours, days, weeks, or months)?* _____
- *If you have had more than one such period, do they occur in a particular **season**?* _____

Have you ever had one or more experiences where you *saw, heard, or felt anything* (in your skin or body) that were bizarre or frightening, that others could not also see/hear/feel, or that others would not believe, or you thought they wouldn't believe (e.g., hear noises or voices; see people, animals, objects, flashes of light; feel you have a disease for which there is no medical evidence, etc.)? **___ yes ___ no**

If yes, please briefly explain: _____
_____
_____

Have you ever experienced a rape or other forced/unwanted sexual behavior, an assault, mugging, other violent crime, serious automobile accident, or any other serious threat to your life or physical integrity? **___ yes ___ no**
Explain (*when, by whom, etc*.) _____
_____

Have you ever been abused or molested in any of the following ways?

verbally/emotionally **___ yes ___ no** By whom? _____
At what age(s)? _____
In what way(s)? _____

physically **___ yes ___ no** By whom? _____
At what age(s)? _____
In what way(s)? _____

sexually **___ yes ___ no** By whom? _____
At what age(s)? _____
In what way(s)? _____

Have you recently (or currently) experienced *thoughts* of seriously injuring or killing yourself? **___ yes ___ no**
Please explain: _____
_____

Have you ever contemplated, planned for, or attempted suicide in *any* way? **___ yes ___ no**
If yes: How many times? _____ Please describe each instance, and how old you were each time:
_____
_____

Have you ever had a tendency to cut, punch, burn, or otherwise directly cause *harm or injury to yourself* in any way?

___ yes ___ no
Please explain: _____
_____

Have you recently (or currently) experienced *thoughts* of seriously injuring or killing someone? **___ yes ___ no**
Please explain: _____

Have you ever attempted to hurt or kill someone other than yourself? **___ yes ___ no**
Please explain: _____

Have you noticed *any change in your energy level* recently? **___ yes ___ no**
Increased or decreased (which one)? _____
Since when? _____

Have you noticed *any change in your appetite* recently? **___ yes ___ no**
Increased or decreased (which one)? _____
Since when? _____

Have you noticed *any change in your weight* recently, <u>not due to dieting</u>? **___ yes ___ no**
Increased, or decreased (which one)? _____
Since when?_____

Have you ever been **hospitalized** because of emotional or psychological problems (including suicide attempts, psychosis, eating disorders, "nervous breakdown," drug overdose, etc.)? **___ yes ___ no**

Name of facility or hospital
_____ From when: _____ To: _____

For what condition or concern(s)? _____
_____

Have you ever, before today, sought, consulted, or received any form of **psychological testing, counseling, psychotherapy, psycho-analysis, addictions/substance abuse support, or other services** for concerns or difficulties that were of a psychological, emotional, or behavioral nature (other than evaluations or examinations for learning disorders or ADHD)? **___ yes ___ no**

Type of service	For what type of condition(s) or concern(s)	When started?	For how long?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Name(s), address(es), and telephone/fax numbers of current and/or most recent counselor, psychotherapist, and/or psychiatrist: (Please indicate whether this person is CURRENT or MOST RECENT.)

_____
_____
_____
_____
_____

If you are currently seeing another mental health services provider, or have seen one in the past, we may want or need to consult with him or her. May we? **___ yes ___ no**

Have you ever taken any **prescription or over-the-counter medications** (including other people's prescriptions) to help you deal with anxiety, stress, depression, bipolar disorder, psychosis, attention-deficit disorder, sleep problems, "nerves", or other psychological/emotional/behavioral concerns? **___ yes ___ no**

Who prescribed these medications? _____ ___ *Do not know*
Is this person a family physician, psychiatrist, nurse, or other? _____
Where does he/she practice? _____
_____

Name of each medication	Dosage (milligrams) & # of times per day	When taken, for how long?
_____	_____	From: _____ To: _____
_____	_____	From: _____ To: _____
_____	_____	From: _____ To: _____
_____	_____	From: _____ To: _____
_____	_____	From: _____ To: _____

VI. ALCOHOL and DRUG USE HISTORY

Check any of the folowing you have *used or tried* in your life:	Age at first use:	Last used when?
_____ alcohol	_____	_____
_____ amphetamine/speed	_____	_____
_____ tobacco	_____	_____
_____ LSD/psychodelics/PCP	_____	_____
_____ marijuana	_____	_____
_____ heroin/morphine/opium	_____	_____
_____ cocaine/crack	_____	_____
_____ glue/solvents/inhalants	_____	_____
_____ Ecstasy/XTC	_____	_____
_____ tranquilizers/sleeping pills/sedatives	_____	_____
_____ other(s): _____	_____	_____
_____	_____	_____

Do you *ever* consume ALCOHOL at all? **___ yes ___ no**

Days since most recent drink: _____
Average number of *days per week* you drink: _____
Number of drinks per day (one beer = one shot = one glass of wine): Minimum = ____ Maximum = ____
Have you ever attempted (or felt you should) to cut down on your drinking? **___ yes ___ no**
Have other people ever annoyed you by criticizing your drinking? **___ yes ___ no**
Have you ever felt guilty about your drinking? **___ yes ___ no**

Have you ever taken a drink in the morning to steady your nerves or to get rid of a hang-over? **___ yes ___ no**

Have you ever noticed a need to use more alcohol to get the usual effect? **___ yes ___ no**

Have you consumed or used any *alcohol, marijuana, or other any other recreational/illicit substances* (e.g., heroin, cocaine, glue, amphetamines, etc.) **within the last month**? **___ yes ___ no**

Name of substance	Days since most recent use	Average *amount per day*	# of days per week of use
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

How often do you use each of the following?		How much per day?	# of days since last use?
beer:	_____days per week	_____	0 1 2 3 4 5 6 7+
wine:	_____days per week	_____	0 1 2 3 4 5 6 7+
liquor:	_____days per week	_____	0 1 2 3 4 5 6 7+
marijuana:	_____days per week	_____	0 1 2 3 4 5 6 7+
cocaine/crack:	_____days per week	_____	0 1 2 3 4 5 6 7+

other illicit/recreational drugs (e.g, Ecstasy/XTC, methamphetamine, etc.):

type #1: _____ # of days since last use?
_____ days per week amt. per day: _____ 0 1 2 3 4 5 6 7+

type #2: _____ # of days since last use?
_____ days per week amt. per day: _____ 0 1 2 3 4 5 6 7+

type #3: _____ # of days since last use?
_____ days per week amt. per day: _____ 0 1 2 3 4 5 6 7+

Have you ever, for any reason, used more of a **prescription medication** (e.g., Oxycontin, Oxycodone, etc.) than was prescribed, or used a prescription medication for any reason other than why it was prescribed? **___ yes ___ no**

If yes, what medication(s) Why? How much? For how long?
type #1: _____
type #2: _____
type #3: _____

If you smoke **tobacco**, then how many packs of cigarettes do you smoke per week? _____ Per day? _____
At what time of day do you usually have your first (tobacco) cigarette? _____

If you drink colas, teas, or coffees, how many **caffeinated** beverages do you tend to drink in a day? _____
At what time of day do you usually have your first caffeinated beverage? _____

Have you ever been accused of, charged with, and/or convicted of any alcohol or drug related violation or crime? **___ yes ___ no**

Explain (*the charge, when, whether or not you were convicted, etc.*): _____
_____

Have you ever recieved INPATIENT or RESIDENTIAL treatment for alcohol and/or drug abuse or dependence? **___ yes ___ no**

Name of facility or hospital	Time period(s)	
_____	From: _____	To: _____
_____	From: _____	To: _____

Have you ever received OUTPATIENT treatment for alcohol and/or drug abuse or dependence? **___ yes ___ no**

Type of service	For what type of condition(s) or concern(s)	When started?	For how long?
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever attended Alcoholics Anonymous (AA), Narcotics Anonymous (NA), Al-Anon, or any other type of support group? **___ yes ___ no**

Type of group: _____ From when: _____ To: _____
Type of group: _____ From when: _____ To: _____

Type of group: _____ From when: _____ To: _____
Type of group: _____ From when: _____ To: _____

VII. MEDICAL/NEUROLOGICAL HISTORY

To your knowledge:
Were you born prematurely? **___ yes ___ no** *If yes, at how many weeks were you born?* _____

What was your birth weight, in pounds and ounces? _____

Did you or your mother have any difficulties during your delivery/birth? **___ yes ___ no**
If yes, then what type(s)? _____

Did your mother use alcohol, tobacco products, cocaine, heroine, or other drugs during her pregnancy with you?
___ yes ___ no Explain: _____

Was she exposed to environmental toxins, such as DDT, lead, mercury, PCB, etc. during her pregancy with you?
___ yes ___ no Explain: _____

Did your mother have any nutritional deficiencies, diabetes, viral infections, or other diseases during her pregnancy with you? **___ yes ___ no** Explain: _____

Were forceps ("tongs") used to deliver you? **___ yes ___ no** Why?: _____

To your knowledge, did you have any difficulty learning to walk, to talk, with toilet training, or with adjusting to attending kindergarten/daycare/school (i.e., in reaching "developmental milestones")? **___ yes ___ no**
Explain: _____
_____

Have you ever been *seriously injured or ill* (e.g., premature birth, cancer, pneumonia, mononucleosis, auto accident, sports injury, job-related injury, extreme fevers [e.g., 104 F or higher], etc.)? **___ yes ___ no**

Type of illness or injury	At what age?	Require hospitalization?
_____	_____	___ yes ___ no
_____	_____	___ yes ___ no
_____	_____	___ yes ___ no
_____	_____	___ yes ___ no
_____	_____	___ yes ___ no

Have you ever experienced a *seizure*, a serious *head injury*, *electrocution*, *poisoning*, one or more instances of *high fevers* (e.g., 103 degrees or higher), or other potential *damage to your brain or nervous system*? **___ yes ___ no**

Type of seizure, injury, poisoning, or damage:	At what age?	Lose consciousness? (if so, for how long?)	Medical exam?
_____	_____	___ no ___ yes, _____	__ yes __ no
_____	_____	___ no ___ yes, _____	__ yes __ no
_____	_____	___ no ___ yes, _____	__ yes __ no
_____	_____	___ no ___ yes, _____	__ yes __ no
_____	_____	___ no ___ yes, _____	__ yes __ no

*** If you have you ever experienced a serious *injury to your head*:**
Was your skull fractured? **___ yes ___ no**
Did you lose consciousness? **___ yes ___ no** For how long?_____
Describe the injury and how it happened: _____
_____
_____
_____
When did this occur (date of event, your age at that time)? _____
_____
_____

*** If you have ever had a *neurological exam* (e.g., CAT scan, an MRI, PET scan, etc.):**

When? _____
What type(s) of test(s)? _____
For what reason?_____
What were the results? _____

*** If you have ever had a *seizure* of any type:**

What type(s)? _____ When was first? _____
How often? _____ How recently? _____
What sorts of things do you experience when you have a seizure? _____
_____
_____

VIII. CURRENT MEDICAL STATUS

Your **primary care physician(s)'s** name: _____
Name and address of the facility/office/clinic you go to: _____
_____
_____

His/Her phone number: _____
How long has it been since your most recent physical exam? _____

Are you predominantly ___ **right-handed** ___ **left-handed** ___ **ambidextrous**

Do you have any difficulties with your ***vision, hearing, coordination, or other sensations/abilities***? **___ yes ___ no**

If yes, please explain: _____
Corrective measures (e.g., eyeglasses/contacts, hearing aids, etc.): _____

Do you currently have any *medical conditions, concerns, or physical discomforts?* **___ yes ___ no**

Disease/disorder, concern, discomfort:	Since when (as specific as possible)?
_____	_____
_____	_____
_____	_____
_____	_____

Do you ever experience attacks or spells characterized by disorientation, confusion, feeling strange, when you cannot control your muscles or movements? **___ yes ___ no**

If "yes" then place a check next to any of the following that apply to you:

__ Are such periods ever preceded by any unusual sensations (e.g., abdominal fullness/pressure/rising feeling)?
__ Are such periods ever followed perhaps by fatigue and/or headache, possibly with poor memory (or even complete amnesia) after the event?
__ Do you ever fall down at any time during the event?
__ Do you experience any muscle jerks during the event (*convulsions*)?
__ Are any such events preceded by a few hours or even days of altered/unusual mood?

Place a check next to any of the following that apply to you:

__ Any experiences (possibly told to you by others) of sudden, repetitive behaviors "out of the blue" that you don't feel you control? (e.g., lip smacking, chewing, gagging, tapping, spitting, grimacing, spitting, laughing)
__ Any experience of strong smells and/or tastes "out of the blue"
__ Any experience of flashes of light, lines, animated figures, or other unusual visual percepts
__ Any experience of objects appearing too small, too large, or otherwise distorted
__ Any experience of auditory clicks, buzzes, voices, music, etc "out of the blue"
__ Any experience of things sounding too soft, too loud, or otherwise altered/distorted
__ Any experience of a sense of profound meaning, of extreme significance during an event or "out of the blue"
__ Any experience of sudden intense terror/panic, rage, depression, anxiety, "out of the blue" that resolves quickly
__ Any experience of things feeling unreal, of your body feeling unreal or not your own *(derealization*)
__ Any experiences of things feeling as if you've been through them before (*déjà vu*)
__ Any experiences of thoughts or memories intruding into your mind with unusual force

__ Are you one to write a great deal, sometimes to the amazement or even annoyance of others
__ Have you ever experienced any notable decrease (or increase) in sexual activity, interest, or targets of sexual interest

IX. MEDICATIONS & ALLERGIES

Are you currently taking any *prescription or over-the-counter medications*, including homeopathic substances (e.g., St. John's wort, ginseng, etc.)? **___ yes ___ no**

medication/substance	For condition/reason?	Dosage/amount per day	Since when (specifically)?

Are you **allergic** to any forms of medications or to anything else (e.g, shellfish, soap, pollen, pet dander, etc.)? **___ yes ___ no**

Thing you are allergic to:	Since when (as specific as possible)?

X. FAMILY HISTORY

To your knowledge, do any of your *immediate or distant relatives* have any history of emotional, behavioral, psychological, or psychiatric difficulties or disorders (e.g., depression, PTSD, anxiety, schizophrenia, bipolar disorder, "manic-depressive" disorder, "nervous breakdown," obsessive-compulsive disorder, etc.)?**___ yes ___ no**

His/Her relation to you	Type of disorder or difficulty	Has he/she ever been treated for it?

To your knowledge, do any of your *immediate or distant relatives* have any history of **learning disorder(s) or Attention-Deficit/Hyperactivity Disorder**? **___ yes ___ no**

His/Her relation to you	Type of disorder or difficulty	Has he/she ever been treated for it?

Do any of your *immediate or distant relatives* have any history of difficulties with alcohol/drugs? **___ yes ___ no**

His/Her relation to you	Type of disorder or difficulty	Has he/she been treated for it?

Do any of your **immediate or distant relatives** have a history of serious medical or health-related concerns (e.g., high blood pressure, cancer, stroke, heart disease, Alzheimer's Disease, other dementias, etc.)?**___ yes ___ no**

His/her relation to you	Type of disease, disorder, or difficulty

XI. DEVELOPMENTAL, EDUCATIONAL and SOCIAL HISTORY

You are the 1st 2nd 3rd 4th 5th other -born child out of _____ (number of children in your family)?

Have you ever had difficulties (e.g., legal) with, or as a result of, your temper/anger/aggression? **___ yes ___ no**
If yes, please explain: _____
_____

Have you ever been charged with and/or convicted of a misdemeanor crime or felony? **___ yes ___ no**
Explain (*the charge, when, whether or not you were convicted, etc.*): _____
_____

Are you currently involved in any litigation or legal procedings? **___ yes ___ no**
Explain (*what type of litigation, for what reasons, etc.*): _____
_____

Mother's highest education level: _____Father's: _____

Schools you have attended	Public, or private?	What years?	Area(s) of study
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

What grades/marks did you receive in **elementary school**? _____
In what areas did you excel or do particularly *well*? _____
In what areas did you fail or do particularly *poorly*? _____

What grades/marks did you receive in **middle school**? _____ GPA: _____
In what areas did you excel or do particularly *well*? _____
In what areas did you fail or do particularly *poorly*? _____

What grades/marks did you receive in **high school**? _____ GPA: _____
In what areas did you excel or do particularly *well*? _____
In what areas did you fail or do particularly *poorly*? _____

What grades/marks do you receive in **college**? _____ GPA: _____
In what areas did you excel or do particularly *well*? _____
In what areas did you fail or do particularly *poorly*? _____

SAT scores: Verbal = _____ Math = _____ Total = _____
GRE scores: General = _____ Subject = _____

Did you have any difficulties with starting school in kindergarten or first grade? **___ yes ___ no**
If yes, please explain: _____

Have you had any history of difficulties learning to read, spell, use grammar/punctuation properly? **___ yes ___ no**
If yes, please explain: _____
_____
_____

Have you ever had trouble doing homework? **___ yes ___ no**
If yes, then what type(s) of difficulty? _____
_____

What do you do (or, have you done in the past) to compensate for the difficulty? _____
_____

Were you ever in any special classes in school, or receive any type of remedial instruction? **___ yes ___ no**

If yes, please explain: _____
_____

Did you ever repeat a grade for any reason? **___ yes ___ no**
If yes, please explain: _____
_____

Have your parents or teachers ever complained that you were difficult to control as a child? **___ yes ___ no**
If yes, around what age did they first have this complaint? _____

Did you ever get into physical fights at school (or any where else)? **___ yes ___ no**
If yes, please explain: _____
_____

Have you ever been suspended or expelled? **___ yes ___ no**
If so, in what grade(s), and why? _____
_____

Have you ever been evaluated for (or been told that you have) a "learning disability," learning disorder, or an Attention-Deficit (with or without hyperactivity) Disorder (ADHD)? **___ yes ___ no**
By whom? _____ When? _____
Diagnosis/disorder(s)? _____
_____

NOTE: *IF YOU HAVE EVER BEEN FORMALLY EVALUATED BY ANYONE, PLEASE PROVIDE A COPY OF THE REPORT, OR HAVE ONE FORWARDED TO US AT THE EARLIEST CONVENIENCE BY YOUR EVALUATOR.*

XII. WORK/VOCATIONAL HISTORY

What is your *current occupation*? _____
Name of your business or employer: _____
How long with this business/employer? _____
Describe your **satisfaction**, or **lack of satisfaction**, with your *job/work situation*: _____
_____
_____

Have you had any difficulties getting jobs, keeping jobs, getting along with employers/co-workers? **___ yes ___ no**
_____
_____
_____

In your work, what are some of your weaknesses (things you do poorly, get criticized for, struggle with, etc.)?
_____
_____
_____

Have you ever been *fired* or *asked to resign*? **___ yes ___ no**
Most recent time: please explain: _____
_____
From what position(s)? _____ When? _____

First time: please explain: _____
_____
From what position(s)? _____ When? _____

XIII. IMPACTS ON LIFE FUNCTIONING

	Not at all true			Moderately true			Severely true
Unable to study effectively:	1	2	3	4	5	6	7 N/A

Unable to attend classes:	1	2	3	4	5	6	7	N/A
Unable to complete assignments:	1	2	3	4	5	6	7	N/A
Unable to fulfill job demands:	1	2	3	4	5	6	7	N/A
Unable to concentrate/focus:	1	2	3	4	5	6	7	N/A
Unable to meet others:	1	2	3	4	5	6	7	N/A
Unable to maintain friendships:	1	2	3	4	5	6	7	N/A
Unable to approach others for help:	1	2	3	4	5	6	7	N/A
Unable to tolerate aloneness	1	2	3	4	5	6	7	N/A
Unable to manage uncomfortable feelings:	1	2	3	4	5	6	7	N/A
Unable to manage impulses:	1	2	3	4	5	6	7	N/A
Unable to refrain from alcohol/drug use/misuse/abuse:	1	2	3	4	5	6	7	N/A
Unable to experience good health:	1	2	3	4	5	6	7	N/A

How many days of school/work have you missed in the last 30 days due to:
medical/physical problems? _____ stress/mental/emotional difficulties? _____ sleep difficulties/fatigue? _____

XIV. GOALS/OBJECTIVES FOR PSYCHOLOGICAL CONSULTATION(S)

Please list your primary goals/needs for our consultations (e.g., ways in which you believe you want or need to be THINKING, FEELING, and/or BEHAVING differently). Please be as specific as possible.

1. _____

2. _____

3. _____

Your signature: _____ Date questionnaire completed: _____

XV. FOR THOSE SEEKING PSYCHOEDUCATIONAL ASSESSMENT/TESTING FOR LEARNING DISORDERS AND/OR ATTENTION-DEFICIT/HYPERACTIVITY DISORDERS

We most likely will need to contact additional persons for information to aid in this assessment now or in the near future. **PLEASE PROVIDE EACH OF THE FOLLOWING:**

I. Mother's full name: _____
Mailing address: _____
_____
_____
daytime phone: _____

II. Father's full name: _____
Mailing address: _____
_____
_____
daytime phone: _____

III. Full name of SPOUSE or SOMEONE ELSE who <u>currently</u> knows you well and spends time with you:

Mailing address: _____
_____
_____

daytime phone: _____

IV. Names of two teachers/instructors from grades 1 – 12 (the earlier, e.g., 1st – 6th grades, the better):

Teacher/instructor #1: _____
Mailing address: _____
_____
_____

daytime phone: _____

Teacher/instructor #2: _____
Mailing address: _____
_____
_____

daytime phone: _____

MUST READ AND SIGN: *By my signature, I authorize Dr. Amy L. Rhodes and/or her agents to interview by phone, in person, and/or by mail any and all of the persons listed above, for the purpose of psychodiagnostic assessment, for no more than six months after the date of my signature, below.*

Your signature: _____

Date you completed this questionnaire: _____

VERY IMPORTANT NOTE: For psychoeducational assessments, it is *essential* that you collect and provide to us copies of any and all report cards, work performance rating reports, transcripts, previous psychological evaluation/assessment reports, and any other documented indications of your performance and abilities in academic, vocational, intellectual, emotional, and behavioral capacities. Please begin to collect these immediately from as many potential sources as you can. Original copies will be returned to you at the conclusion of our assessment process.