**BACKGROUND INFORMATION FORM**

Patient Identification Label

**ADULT BEHAVIORAL HEALTH**

**Instructions:** To help us offer you the highest quality service, please fill out this form as fully and openly as possible. This information is held in **strict confidence** within legal limits. Please fill out as much information as you can; however, if the information is too overwhelming or too triggering, feel free to skip that question or section.

**Date Completed:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Referred By:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***BASIC INFORMATION:***

Name (First, MI, Last) \_\_\_\_\_­­­­­\_\_\_\_\_\_\_\_\_­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Name: \_\_­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age: \_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***ETHNIC ORIGIN:***

\_\_\_\_\_\_ African American \_\_\_\_\_\_ Asian \_\_\_\_\_\_ Caucasian \_\_\_\_\_\_ Hispanic \_\_\_\_\_\_ Native American

\_\_\_\_\_\_ Other: (Please Note) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***RELATIONSHIP STATUS:***

\_\_\_ Single \_\_\_ Dating \_\_\_ Married \_\_\_ Separated/Divorced \_\_\_ Widowed \_\_\_ Remarried \_\_\_ Partnered

***AREAS OF CONCERN:***

Please describe problems/concerns for which you are seeking help: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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***PREVIOUS MENTAL HEALTH CARE RECEIVED:*** Please indicate below what the **treatment** was for (e.g. depression, anxiety, etc.), the **approximate date** the treatment started (it’s okay to estimate), the name of the treatment **facility or provider**, the **type of care** you received (e.g. individual therapy, family/couples therapy, hospitalization, etc.), the **outcome** of treatment (poor, fair, good, excellent, etc.) and **how long** treatment lasted.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Treatment For** | **Year started** | **Facility and Provider** | **Type of Care** | **Outcome** | **How Long did you receive treatment?** |
|  |  |  |  |  |  |
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\*C-SSRS (If yes to any of 1-3, provider please administer the complete SSRS)

1. Have you ever wished you were dead or wished you could go to sleep and not wake up? \_\_\_ Yes \_\_\_ No
2. Have you actually had any thoughts of killing yourself?\* \_\_\_ Yes \_\_\_ No
   1. If **yes**, please answer the following questions:
      1. Have you been thinking of how you might kill yourself? \_\_\_ Yes \_\_\_ No
      2. Have you had these thoughts and had some intention of acting on them? \_\_\_ Yes \_\_\_ No
      3. Have you started to work out or worked out the details of how to kill yourself? \_\_\_ Yes \_\_\_ No
         1. Do you intend to carry out this plan? \_\_\_ Yes \_\_\_ No
3. Have you ever done anything, started to do anything, or prepared to do anything to end your life?\* \_\_ Yes \_\_ No
   1. If **yes**, how long ago did you do any of these?\* \_\_\_ within the last 3 months \_\_\_ 4-12 mo ago \_\_\_ over a year ago
4. Do you currently engage in self-harm (i.e., cutting, burning self) or have thoughts of doing this? \_\_\_ Yes \_\_\_ No
5. Do you have thoughts of harming someone else? \_\_\_ Yes \_\_\_ No

**SUBSTANCE USE AND ADDITIVE BEHAVIORS:** \*CAGE-AID

* + - 1. Have you ever felt you ought to cut down on your drinking or drug use?\* \_\_\_ Yes \_\_\_ No
      2. Have people annoyed you by criticizing your drinking or drug use?\* \_\_\_ Yes \_\_\_ No
      3. Have you ever felt bad or guilty about Your drinking or drug use?\* \_\_\_ Yes \_\_\_ No
      4. Have you ever had a drink *or used drugs* first thing in the morning to steady your nerves or to get rid of a hangover?\* \_\_\_ Yes \_\_\_ No
      5. Do you drink alcohol?\* \_\_\_ Yes \_\_\_ No
         1. If **yes**, how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approximately how much each time? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was the last time that you drank? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* + - * 1. If **no**, have you drank alcohol in the past? \_\_\_ Yes \_\_\_ No

If **yes**, when is the last time that you drank? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* + - 1. Do you use street drugs (including, but not limited to cocaine, meth, marijuana)? \_\_\_ Yes \_\_\_ No
         1. If **yes**, what kind? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* + - * 1. If **no**, have you ever experimented with drugs?\* \_\_\_ Yes \_\_\_ No

If **yes**, when is the last time that you used? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* + - 1. Do you use tobacco products? \_\_\_ Yes \_\_\_ No
         1. If **yes**, what kind (cigarettes, chew, e-cigs, etc.)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Would you like information on how to quit? \_\_\_ Yes \_\_\_ No

* + - 1. Have you ever misused prescription medications? (e.g. pain pills or anxiety pills) \_\_\_ Yes \_\_\_ No
         1. If **yes**, what have you used and when?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
      2. Do you use any other chemicals to obtain a high? (e.g. synthetic drugs, bath salts, etc.)? \_\_\_ Yes \_\_\_ No
         1. If **yes**, what have you used and when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
      3. Has alcohol or drug use caused any problems in the past? \_\_\_ Yes \_\_\_ No
         1. If **yes**, what kind of problems? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
      4. Have you ever been in chemical dependency treatment? \_\_\_ Yes \_\_\_ No
         1. If **yes**, how many times, for what chemical, and when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
         2. Did you successfully complete each program? Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
      5. Do you consume caffeinated beverages? \_\_\_ Yes \_\_\_ No
         1. If **yes**, what beverage, how much, and how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
      6. Do you gamble? \_\_\_ Yes \_\_\_ No
         1. If **yes**, how often? \_\_\_\_ Daily \_\_\_\_ Weekly \_\_\_\_ Monthly \_\_\_\_ Occasionally
         2. Have you ever lost more money than you could comfortably afford? \_\_\_ Yes \_\_\_ No
      7. Do you find that you spend more money while shopping (either in person or online) than you could comfortably afford? \_\_\_ Yes \_\_\_ No
         1. If **yes**, how often? \_\_\_\_ Weekly \_\_\_\_ Monthly \_\_\_\_ Occasionally
      8. Do you spend an excessive amount of time on the internet, so much so that it distracts from your ability to complete daily required tasks (i.e., self-care, work, childcare, sleep)? \_\_\_ Yes \_\_\_ No
         1. If **yes**, how often? \_\_\_\_ Weekly \_\_\_\_ Monthly \_\_\_\_ Occasionally

**CURRENT LIFE SITUATION:**

1. ***Current Family Information:***
   1. Are you currently in a committed relationship? \_\_\_ Yes \_\_\_ No
      1. If so, what is your significant other’s name? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Their Age \_\_\_\_\_\_
   2. Are you currently married or partnered? \_\_\_ Yes \_\_\_ No
      1. If **yes**, how long have you been married/partnered? (\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_years)
      2. Type of relationship: \_\_\_\_ Close \_\_\_\_ Conflicted \_\_\_\_ Supportive \_\_\_\_ Distant \_\_\_\_ Neutral
   3. If you are separated, divorced or widowed, how long has it been? (\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_years)
   4. How many times have you been married? (\_\_\_\_\_\_\_\_\_\_\_\_\_times)
   5. If you have children, please complete the following (add a page if you need more room):

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Child’s Name** | **Age** | **Gender** | **Child lives with me:** | | **If “No”, who does he/she live with and where?** |
| **Yes** | **No** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

* 1. Have you had any miscarriages or stillbirths? \_\_\_ Yes \_\_\_ No

How Many? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. ***Current Living Arrangements*:**
   1. Please describe your current living situation (e.g. own home, rent an apartment, living with friends/family, retirement community, group home, homeless in a shelter, etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   2. Nature of Current Relationships: \_\_\_\_ Close \_\_\_\_ Conflicted \_\_\_\_ Supportive

\_\_\_\_ Distant \_\_\_\_ Neutral

* + 1. Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
  1. Are you satisfied with your living situation? \_\_\_ Yes \_\_\_ No
     1. If **no**, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
  2. Besides any children and/or spouse listed above, who else lives in your home?

|  |  |  |
| --- | --- | --- |
| **Person’s Name** | **Age** | **Relationship to You** |
|  |  |  |
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1. ***Family History*:**
   1. How would you describe your childhood? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* 1. Were your parents separated or divorced? \_\_\_ Yes \_\_\_ No
     1. If **yes**, how old were you when that occurred? \_\_\_\_\_\_\_\_\_
     2. Describe the relationship between your parents (check all that apply):

\_\_\_\_ Healthy \_\_\_\_ Loving \_\_\_\_ Supportive \_\_\_\_Neutral \_\_\_\_ Distant

\_\_\_\_ Conflicted \_\_\_\_ Abusive \_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* 1. What is your relationship with your parents like?

\_\_\_\_ Healthy \_\_\_\_ Loving \_\_\_\_ Supportive \_\_\_\_Neutral \_\_\_\_ Distant

\_\_\_\_ Conflicted \_\_\_\_ Abusive \_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* + 1. Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
  1. Do you have any siblings? \_\_\_ Yes \_\_\_ No
     1. If **yes**, how many brothers? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How many sisters? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
        1. Your place in birth order: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
  2. What is your relationship with your siblings like?

\_\_\_\_ Healthy \_\_\_\_ Loving \_\_\_\_ Supportive \_\_\_\_Neutral \_\_\_\_ Distant

\_\_\_\_ Conflicted \_\_\_\_ Abusive \_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* 1. Other important family information or events that you would like your provider to know: \_\_\_\_\_\_\_\_\_\_\_\_

1. ***Current Life Relationships*:**
   1. Friendships/Support System: \_\_\_\_\_ Many \_\_\_\_\_ Few \_\_\_\_\_ None
   2. Nature of Relationships: \_\_\_\_\_ Supportive \_\_\_\_\_ Draining \_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   3. Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. ***Legal Issues*:**
   1. Are you currently involved in any legal difficulties (e.g. DWI, divorce, lawsuit, custody dispute, felony, probation, traffic, etc.)? \_\_\_ Yes \_\_\_ No
      1. If **yes**, briefly describe your difficulties: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* 1. Have you had any other legal problems in the past? \_\_\_ Yes \_\_\_ No
     1. If **yes**, briefly describe your difficulties: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. ***Cultural and Spiritual Factors*:**
   1. Do you identify with any specific religious, spiritual or cultural affiliation? If so, what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   2. Do you participate in any religious, spiritual or cultural practices (such as church, pow-wo, culturally specific activities)? \_\_\_ Yes \_\_\_ No
      1. If **yes**, what practices? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How Often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   3. Additional comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. ***Education*:**
   1. Years of schooling (0 to 16+): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   2. Diploma or highest degree received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   3. Any history of learning difficulties? \_\_\_ Yes \_\_\_ No
      1. If **yes**, please check all areas of difficulty you have experienced in the area of learning:

\_\_\_\_ Concentration \_\_\_\_ Hearing \_\_\_\_ Listening \_\_\_\_Reading \_\_\_\_ Writing

\_\_\_\_ Memory \_\_\_\_ Other

* + 1. Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
  1. Have you ever been diagnosed with a learning disorder? \_\_\_ Yes \_\_\_ No
     1. If **yes**, by whom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
     2. Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. ***Employment*:**
   1. Are you currently employed? \_\_\_ Yes \_\_\_ No
      1. If **yes**, where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
      2. What is your job title? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
      3. Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   2. Work Environment:

\_\_\_ Challenging \_\_\_ Stressful \_\_\_ Supportive \_\_\_ Rewarding \_\_\_ Unhealthy \_\_\_ Not applicable

* 1. Any history of difficulties with employment? \_\_\_ Yes \_\_\_ No
     1. If **yes**, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* 1. Do you currently receive Social Security benefits? \_\_\_ Yes \_\_\_ No \_\_\_ Applying
     1. Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. ***Military Service*:**
   1. Have you served in the military? \_\_\_ Yes \_\_\_ No
      1. If **yes**, when? From \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
         1. What branch of service? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
         2. Highest rank obtained: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
         3. Type of Discharge: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***MEDICAL OVERVIEW*:**

1. Primary Care Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Primary Care Clinic: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Psychiatric (Mental Health Medication) Provider and Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Please list current and past **medical conditions** (Please use comments section on back page if needed):

|  |
| --- |
| **Conditions** |
|  |
|  |
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1. General Health – Please respond to each question or statement by marking one box per row: \*PROMIS v1.2

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| In general, would you say your health is: | | | | | | | Excellent | Very Good | Good | | Fair | Poor |
| In general, would you say your quality of life is: | | | | | | | Excellent | Very Good | Good | | Fair | Poor |
| In general, how would you rate your physical health: | | | | | | | Excellent | Very Good | Good | | Fair | Poor |
| In general, how would you rate your mental health, including your mood and ability to think: | | | | | | | Excellent | Very Good | Good | | Fair | Poor |
| In general, how would you rate your satisfaction with your social activities and relationships: | | | | | | | Excellent | Very Good | Good | | Fair | Poor |
| In general, please rate how well you carry out your social activities and roles (activities at home, at work and in your community, and responsibilities as a parent, child, spouse, employee, friend) | | | | | | | Excellent | Very Good | Good | | Fair | Poor |
| To what extent are you able to carry out your everyday activities such as walking, climbing stairs, carrying groceries or moving a chair? | | | | | | | Excellent | Very Good | Good | | Fair | Poor |
| In the last 7 days, how often have you been bothered by emotional problems such as feeling anxious, depressed or irritable? | | | | | | | Excellent | Very Good | Good | | Fair | Poor |
| In the last 7 days, how would you rate your fatigue on average? | | | | | | | Excellent | Very Good | Good | | Fair | Poor |
| In the last past 7 days, how would you rate your pain on average? | 0  No pain | 1 | 2 | 3 | 4 | 5 | 6 | 7 | | 8 | 9 | 10  Worst pain imaginable |

1. Have you ever:
   1. Had a concussion? \_\_\_ Yes \_\_\_ No
      1. If **yes**, list how many and what caused them: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
         1. Did you receive medical treatment after? \_\_\_ Yes \_\_\_ No
   2. Had a loss of consciousness? \_\_\_ Yes \_\_\_ No
      1. If **yes**, list how many and what caused them: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
         1. Did you receive medical treatment after? \_\_\_ Yes \_\_\_ No
   3. Had a seizure? \_\_\_ Yes \_\_\_ No
      1. If **yes**, list how many and what caused them: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
         1. Did you receive medical treatment after? \_\_\_ Yes \_\_\_ No
2. Developmental Issues:
   1. Mother’s approximate age when she had you: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   2. Any complications that she had with her pregnancy, labor or delivery with you? \_\_\_ Yes \_\_\_ No
      1. If **yes**, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   3. Any developmental issues that you had? (e.g. slow to walk, talk, potty train) \_\_\_ Yes \_\_\_ No
      1. If **yes**, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Please list all current **medication(s)** and the reason they are prescribed:

|  |  |
| --- | --- |
| **Medication** | **Purpose** |
|  |  |
|  |  |
|  |  |
|  |  |

1. Please list any **allergies**, and the type of reactions you have (e.g. rash, nausea, trouble breathing).

|  |  |
| --- | --- |
| **Allergy to What?** | **Type of Reaction** |
|  |  |
|  |  |
|  |  |

1. Are there any medical conditions in your immediate family (including biological family, as well as your own family and children): \_\_\_ Yes \_\_\_ No
   1. If **yes**, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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***FAMILY MENTAL HEALTH AND CHEMICAL HISTORY*:** For each condition listed below, please identify any immediate family member who has experienced the condition:

1. Alcohol or Drug Use (list type of use): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Anxiety: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Bipolar Disorder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Depression (including any suicide attempts or completions): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Eating Disorder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Learning Disorder/Cognitive Disorder/A-D/HD: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Other (please list): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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***REVIEW OF SYMPTOMS*:**

***MOOD –***

*Part I:* The following is alist of questions about things you may be experiencing:

1. Do you have history of depression or are you currently feeling depressed? \_\_\_ Yes \_\_\_ No
2. If **yes**, does your depression come and go? \_\_\_ Yes \_\_\_ No

If **yes**, how many times has it done so?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If **no**, has it been there continuously most of your life? \_\_\_ Yes \_\_\_ No

1. How old were you when you were first depressed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Does the depression get worse in the winter? \_\_\_ Yes \_\_\_ No
3. Is your depression (or anxiety/irritability) worse before your periods? \_\_\_ Yes \_\_\_ No \_\_\_N/A
4. Are you going through menopause? \_\_\_ Yes \_\_\_ No \_\_\_ N/A

If **yes**, has your depression gotten worse in the midst of this change? \_\_\_ Yes \_\_\_ No

1. Please check the symptoms of depression that you are **currently** experiencing: \*PHQ-9

\_\_\_ Little interest or pleasure in doing things\* \_\_\_ Depressed mood\* \_\_\_ Hopeless feeling\*

\_\_\_ Trouble sleeping (too much/little)\* \_\_\_ Little or no energy\* \_\_\_ Low motivation

\_\_\_ Loss of appetite/overeating\* \_\_\_ Feeling worthless (bad about self)\* \_\_\_ Poor concentration\*

\_\_\_ Moving slowly\* \_\_\_ Feeling agitated or stirred-up\* \_\_\_ Memory impaired

\_\_\_ Thoughts of wanting to die\* \_\_\_ Irritability \_\_\_ Recent weight loss

\_\_\_ Excessive guilt \_\_\_ Withdrawing from others

*Part II:* Has there ever been a period of time when you were not your usual self and …:(Check all that apply\*MDQ)

\_\_\_ Felt extremely good or hyper \_\_\_ Had trouble concentrating

\_\_\_ Shouted at people or started arguments \_\_\_ Had much more energy

\_\_\_ Felt incredibly self-confident \_\_\_ Were much more active or did more things

\_\_\_ Got much less sleep and didn’t miss it \_\_\_ Spent more money than you could afford

\_\_\_ Couldn’t slow your mind down \_\_\_ Talking more loudly or faster than usual

\_\_\_ Did things others thought were excessive, foolish or risky \_\_\_ Felt driven to do fun things

\_\_\_ Felt sudden changes in mood \_\_\_ Felt more irritable and angry

\_\_\_ Had trouble sitting still

\_\_\_ Hard time getting to sleep

If you checked more than one of the above, have several of these ever happened during the same period of time?\*

\_\_\_ Yes \_\_\_ No

How much of a problem did any of these cause you (like being unable to work; having family, money or legal troubles; getting into arguments or fights)?\* \_\_\_ No problem \_\_\_ Minor problem \_\_\_ Moderate problem \_\_\_ Serious problem

***ANXIETY*:**

Please check all of the following that apply:

\_\_\_ Frequent nervousness or anxiousness

\_\_\_ Frequent worry about a number of things

\_\_\_ Anxious or uncomfortable about being in a social setting

\_\_\_ Muscle/tension pain

\_\_\_ Upset stomach

\_\_\_ Pictures in your mind that play over and over

\_\_\_ Being especially afraid of certain things. Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Feeling driven to do certain things over and over to feel less nervous? Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had a sudden attack of intense fear or discomfort that included: (Check all that apply)

\_\_\_ Pounding/racing heart \_\_\_ Chest pain/discomfort \_\_\_ Feel like you are dying

\_\_\_ Sweating \_\_\_ Sick to your stomach \_\_\_ Numbness or tingling

\_\_\_ Trembling/shaking \_\_\_ Feeling like things are not real \_\_\_ Feeling of choking

\_\_\_ Feel like you’re losing control \_\_\_ Lightheadedness \_\_\_ Chills

\_\_\_ Trouble breathing \_\_\_ Feeling like you’re not real

1. How often do these periods of sudden intense fear or discomfort happen?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Do you avoid going places because you are worried you may have an anxiety attack? \_\_\_ Yes \_\_\_ No
3. Do you have to force yourself to go places that you would prefer to avoid because of this worry? \_\_\_ Yes \_\_\_ No

***PERCEPTION AND BELIEFS*:**

1. Do you hear things others don’t hear? \_\_\_ Yes \_\_\_ No
2. Do you see things others don’t see? \_\_\_ Yes \_\_\_ No
3. Do you believe that others are spying on you or are out to get you? \_\_\_ Yes \_\_\_ No
4. Do you think that others are talking about you? \_\_\_ Yes \_\_\_ No
5. Do you think that someone is putting thoughts into your head? \_\_\_ Yes \_\_\_ No
6. Do you believe you have special powers? \_\_\_ Yes \_\_\_ No
7. Do you think that you receive special messages through the TV or radio? \_\_\_ Yes \_\_\_ No

***ATTENTION/CONCENTRATION/MEMORY*:**

1. Do you have difficulty paying attention and concentrating at work, school, or home? \_\_\_ Yes \_\_\_ No
2. Is it hard for you to sit still for more than ½ hour at a time? \_\_\_ Yes \_\_\_ No
   1. If **yes**, have you had these problems since you were a child? \_\_\_ Yes \_\_\_ No
   2. If **no**, when did this start? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Have you ever been diagnosed with Attention Deficit/Hyperactivity Disorder? \_\_\_ Yes \_\_\_ No
   1. If **yes**, by whom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   2. If **yes**, were you treated with medication? \_\_\_ Yes \_\_\_ No
   3. If **yes**, what medication? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Do you have trouble with your memory? \_\_\_ Yes \_\_\_ No
   1. If **yes**, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   2. If **yes**, how long have you had trouble? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***STRESSFUL LIFE EVENTS AND EXPERIENCES*:**

If you feel comfortable doing so, please answer the following questions about experiences that you may have had in your childhood. Please skip any questions that you do not feel comfortable answering.\*ACES

**While you were growing up, during your first 18 years of life:**

1. Did a parent or other adult in the household **often or very often:\***
   1. Swear at you, insult you, put you down, or humiliate you? \_\_\_ Yes \_\_\_ No
   2. Act in a way that made you afraid that you might be physically hurt? \_\_\_ Yes \_\_\_ No
2. Did a parent or other adult in the household **often or very often:\***
   1. Push, grab, slap, or throw something at you? \_\_\_ Yes \_\_\_ No
   2. Ever hit you so hard that you had marks or were injured? \_\_\_ Yes \_\_\_ No
3. Did an adult or person older than you **ever:\***
   1. Touch or fondle you or have you touch their body in a sexual way? \_\_\_ Yes \_\_\_ No
   2. Attempt or actually have oral, anal, or vaginal intercourse with you? \_\_\_ Yes \_\_\_ No
4. Did you **often or very often** feel that:**\***
   1. No one in your family loved you or thought you were important or special? \_\_\_ Yes \_\_\_ No
   2. Your family didn’t look out for each other, feel close to each other, or support \_\_\_ Yes \_\_\_ No

each other?

1. Did you **often or very often** feel that:**\***
   1. You didn’t have enough to eat, had to wear dirty clothes, and had no one to \_\_\_ Yes \_\_\_ No

protect you?

* 1. Your parents were too drunk or high to take care of you or take you to the \_\_\_ Yes \_\_\_ No

doctor if you needed it?

1. Were your parents **ever** separated or divorced?**\*** \_\_\_ Yes \_\_\_ No
2. Was your mother or stepmother:**\***
   1. **Often or very often** pushed, grabbed, slapped, or had something thrown at her? \_\_\_ Yes \_\_\_ No
   2. **Sometimes, often, or very often** kicked, bitten, hit with a fist, or hit with \_\_\_ Yes \_\_\_ No

something hard?

* 1. **Ever** repeatedly hit at least a few minutes or threatened with a gun or knife? \_\_\_ Yes \_\_\_ No

1. Did you live with anyone who was a problem drinker or alcoholic or who used street \_\_\_ Yes \_\_\_ No

drugs?**\***

1. Was a household member depressed or mentally ill, or did a household member \_\_\_ Yes \_\_\_ No

attempt suicide?**\***

1. Did a household member go to prison?**\*** \_\_\_ Yes \_\_\_ No

If you have had any significant stressful or traumatic experiences, outside of those listed above, please list them below. These could include but are not limited to, being a victim of a crime, a significant loss, witnessing or experiencing any traumatic event, or physical or sexual abuse/assault/rape as an adult.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you had any of these problems **in the past month**, in response to the above noted stressful life experiences?\*PCL

1. Repeated disturbing memories, thoughts, or images of the stressful experience? \_\_\_ Yes \_\_\_ No
2. Repeated, disturbing dreams of the stressful experience? \_\_\_ Yes \_\_\_ No
3. Suddenly acting or feeling as if the stressful experience were happening again \_\_\_ Yes \_\_\_ No

(as if you were reliving it)?

1. Feeling very upset when something reminded you of the stressful experience? \_\_\_ Yes \_\_\_ No
2. Having physical reactions (e.g., heart pounding, trouble breathing, or sweating), when \_\_\_ Yes \_\_\_ No

something reminded you of the stressful experience?

1. Avoiding thinking about or talking about the stressful experience or having feelings \_\_\_ Yes \_\_\_ No

related to it?

1. Avoiding activities or situations because they remind you of the stressful experience? \_\_\_ Yes \_\_\_ No
2. Trouble remembering important parts of the stressful experience? \_\_\_ Yes \_\_\_ No
3. Loss of interest in activities that you used to enjoy \_\_\_ Yes \_\_\_ No
4. Feeling distant or cut off from other people? \_\_\_ Yes \_\_\_ No
5. Feeling emotionally numb or being unable to have loving feelings for those close to you? \_\_\_ Yes \_\_\_ No
6. Feeling as if your future will somehow be cut short? \_\_\_ Yes \_\_\_ No
7. Trouble falling asleep or staying asleep? \_\_\_ Yes \_\_\_ No
8. Feeling irritable or having angry outbursts? \_\_\_ Yes \_\_\_ No
9. Having trouble concentrating? \_\_\_ Yes \_\_\_ No
10. Being “super alert” or watchful or on guard? \_\_\_ Yes \_\_\_ No
11. Feeling jumpy or easily startled? \_\_\_ Yes \_\_\_ No

***WEIGHT AND EATING CONCERNS*:**\*SCOFF

1. Do you make yourself sick because you feel uncomfortably full?\* \_\_\_ Yes \_\_\_ No
2. Do you worry that you have lost control over how much you eat?\* \_\_\_ Yes \_\_\_ No
3. Do you believe yourself to be fat when others say you are too thin?\* \_\_\_ Yes \_\_\_ No
4. Have you recently lost more than fourteen pounds in a three-month period?\* \_\_\_ Yes \_\_\_ No
5. Would you say that food dominates your life?\* \_\_\_ Yes \_\_\_ No

***OTHER CONCERNS*:**

1. Do you experience outbursts of anger? \_\_\_ Yes \_\_\_ No
   1. If **yes**, how often: \_\_\_\_ daily \_\_\_\_ weekly \_\_\_\_ monthly \_\_\_\_ occasionally
2. At times, do you yell, shout or name call? \_\_\_ Yes \_\_\_ No
3. Have you ever been physically violent? \_\_\_ Yes \_\_\_ No
4. Do you have any questions or concerns about your gender or sexual identity? \_\_\_ Yes \_\_\_ No
5. Do you have any concerns about your sex life? \_\_\_ Yes \_\_\_ No
6. Any difficulties with sexual performance? \_\_\_ Yes \_\_\_ No
7. Do you engage in any sexual behavior that concerns you? \_\_\_ Yes \_\_\_ No

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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***INTERESTS, STRENGTHS, AND ABILITIES*:**

* **Hobbies and Leisure Activities:** Please list any hobbies and leisure activities you enjoy:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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* List **strengths and abilities** that you have, that make you who you are:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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***ADDITIONAL COMMENTS*:**

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