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This questionnaire will help us understand the difficulties that you are having. The information that you provide may be included in our report of the findings from this evaluation.

Please answer all of the questions to the best of your ability; it is OK to get help from your family and reliable friends. Some of the questions may make you feel uncomfortable or embarrassed, but we ask that you complete them as completely as possible so that we know as much as possible about your entire history. If you need more space, you can write in the margins or on another sheet of paper.

Person(s) completing questionnaire: _____ Date: _____

Guardian or Legal Representative: _____

BACKGROUND INFORMATION

Name: _____

Phone: Daytime/Work: _____ Evening/Home: _____

Email: _____

Best time and way to reach you during the daytime: _____

****

Date of Birth: _____ Age: _____ Sex: _____ Place of Birth: _____

Handedness (circle one): Right Left Did you ever switch from using one hand to another? Yes / No

Native language: _____ Other Languages: _____

Marital Status: _____ Spouse/Partner's name: _____

If married or committed, how long? _____ Number of years in current relationship: _____
Number of marriages: _____

Children (Names & Ages): _____

_____

Ethnicity/Cultural Identity: _____

Religious/Spiritual Practice: _____

Nature/Frequency of Current Practice: _____

HISTORY OF CURRENT CONCERNS

Please begin by describing what you consider to be the most important problems you have had or are having that relate to this evaluation. Please describe what was wrong when you first noticed your problems, then describe what has happened since then. If possible, include names of physicians you have seen and tests that have been completed with results as you understand them. You may summarize what doctors have told you, but we are very interested in what you feel the problems are.

Date, month, or year your problem occurred or started:

What happened first?

Describe the major problems:

Is the problem still present? Is it stable, worse or improved? What specific problems bother you the most now?

Please describe an example:

Other relevant problems:

EDUCATIONAL BACKGROUND: Please fill in the highest level you **completed** in school:

High school: _____ th Grade Vocational School: _____ (years) Studied: _____

College: _____ (years) Name of College: _____ Major: _____

Graduate School: _____ (years) Name of College: _____

How would you describe your average performance as a student?

Grades in High School _____ A & B _____ B & C _____ C & D _____ D & E

Best subject(s)/grades: _____ Worst subjects(s)/grades: _____

Were you diagnosed or treated for Learning Disability or Attention Deficit/Hyperactivity Disorder? _____

If so, what treatment did you receive? _____

Was treatment effective? _____

Did you repeat any grades? (Yes / No) If so, which grades? _____

Please provide any additional information regarding your school performance:

WORK HISTORY: What is your occupation/job title? _____

What company/organization do you work for? _____

What type of work is required by your job? _____

_____

If you are still working, have the problems for which you are being evaluated influenced your ability to do your work? _____ If yes, please give details:

Please list jobs with length of employment you have held in the past (#1 for most recent):

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

Did you spend any time in the military? (Yes / No) If so, please provide details of your service (Branch, length of duty, discharge status, combat injuries):

If retired, at what age and rank did you retire from the service? _____

PSYCHIATRIC HISTORY: Have you ever been hospitalized for any type of mental illness? If so, how many times, when, and for what reasons?_____

_____

Have you worked with a counselor/therapist before? If so, when, how long, and on what concerns?_____

_____

_____

Has anyone in your family (parents, aunts, uncles, grandparents had a mental illness or been hospitalized for any type of mental illness (nerves, depression, suicide)? If so, please indicate your relationship to the family member and what type of illness or limitations they have or had. _____

_____

Please rate yourself on the following cognitive abilities:

	Very Bad	Bad	Average	Good	Very Good
Ability to concentrate					
Handwriting					
Sense of direction					
Ability to learn new things					
Ability to solve new problems					
Memory for people's names					
Memory for people's faces					
Memory for facts (e.g., the news)					
Memory for daily events					
Memory for past events					

MEDICAL HISTORY

Developmental History: Were you born on time _____ Prematurely _____ Late _____

Weight at birth _____ lbs. _____ oz.
Were there any problems associated with your birth (lack of oxygen, unusual birth position, etc)?

As a child, did you have speech/language problems, developmental delays, learning disability, attention disorder, hyperactivity, vision problems or any other problems?

As a child, did you have any accidents that required hospitalization?

Did you ever suffer any injury to your head, with or without loss of consciousness?

Are you aware of ever being exposed to toxic chemicals at home, school, or work?

Current Status and Problems

Past or current medical conditions: (circle all that apply):

High blood pressure	Heart disease	Bypass surgery	Palpitations/Irregular heart beat
Diabetes	High cholesterol	Cataracts	Fainting spells
Brain injury	Thyroid disease	Depression	Kidney disease
Sleep apnea	Menopause	Vitamin deficiency	HIV/AIDS
Stroke / TIAs	Cancer / tumor	Seizures	Syphilis / other STDs

Please circle any of the following problems you may be having now, or have had in the recent past. Please add any explanations you fell are important.

Headaches	Eye problems	Hearing problems
Lightheadedness	Dryness of eyes	Ringing in ears
Fainting	Double vision	Problems with smell
Dizziness	Drooping of eyelid	Unusual smells
Poor balance	Drooping of mouth	Problems tasting
Weakness of the face	Numbness in face	Unusual tastes
Weakness in arms/hands	Numbness in arms/hands	Chewing/swallowing problems
Weakness in legs	Numbness of feet/legs	Weight gain
Problems walking	Numbness of toes	Weight loss
Problems speaking	Numbness in back/chest	Problems with urination
Dry mouth	Pain, arms or hands	Constipation / Incontinence

Any other medical conditions or symptoms?: _____

Have you ever had a blood transfusion? (Yes / No) If yes, when and why? _____

List all illnesses (or any conditions for which you currently take medications), surgeries and hospitalizations (indicate where), including accidents and minor surgeries:

	Date	Medical Condition	Hospital & City
1.			
2.			
3.			
4.			
5.			
6.			
7.			

MEDICATIONS
Please list the medication you are taking now, how much, how often, the reason you are taking them and when you started (for example, Dilantin, 200 mg, twice/day, for seizures, since 6/95).

Medication	Single Dose	Frequency	Reason	Start Date

If more medications, please attach a printed or typed list to this document.

What side effects do you experience from these medications? _____

_____

Other medications you have used in the recent past (6 months):_____

_____

ALLERGIES: _____

FAMILY HISTORY: Please provide the age and health of your blood relatives, if known. I f the person has any medical or psychiatric problems you are aware of (diabetes, heart disease, depression, memory problems, etc), please note them here. **If deceased, indicate age at death in Age column and write "D" in the next column.*

Relation to You	Age *		Health problems or if deceased, cause of death
Mother			
Father			
Sister(s)			
Brother(s)			
Your Children	**Age ***		**Health problems or if deceased, cause of death**

LIFESTYLE & HABITS:

Do you currently use tobacco/smoke cigarettes? (Yes / No) How much? _____

At what age did you start using/smoking? _____ Age when you stopped using/smoking: _____

Do you currently drink alcohol? (Yes / No) Age when you started drinking: _____

Used to drink but have currently stopped (Yes / No) Age when you stopped drinking: _____

If you currently drink (or used to drink) alcohol, indicate how much you drink on average (if you have stopped, indicate an average of how much you used to drink):

Rarely or never _____ 1-2 days/week _____ 3-5 days/ week _____ Daily _____

Usual number of drinks at one time: _____ Preferred type of drink: _____

Have you ever had legal problems related to your use of alcohol? _____

Have you ever been charged with driving under the influence of alcohol? _____

Have you ever experienced blackouts or loss of recall for events while you were drinking? _____

_____

_____

If you currently use or have used any recreational drugs (for example, marijuana, amphetamines, baribituates, cocaine or crack, hallucinogens, heroin, PCP, Ecstasy or other drugs), please list them:

_____

_____

If you ever used IV/intravenous drugs, what type(s)? _____

_____

Have you ever been treated for drug dependency? _____ If so, for how long, when and what type of program? _____

_____

_____

_____

MOOD & SPIRITS:

How would you describe your mood/spirits today? _____

Do you notice wide mood swings? _____ Do you tend to worry a lot? _____

How do you feel about yourself? _____

Do you often feel guilty or often blame yourself for things? _____

How do you feel about the future? _____

Do you feel capable of making decisions about things? _____

Have you ever seriously felt that life isn't worth living? _____

Have you ever seriously tried to end your life? _____

Do you often feel unenthusiastic now, or feel that you lack drive? _____

Do you find it difficult to get started on things? _____

What do you enjoy doing? _____

Have your interests changed, and if so, how? _____

Have there been any significant changes in:

	No change	Decreased	Increased
Overall activity level			
Eating patterns/enjoyment of food			
Amount of sleep needed			
Amount of sleep each night			
Interest in sex			
Sexual function			
Enjoyment of usual activities			
Interest in other people			

Is there any additional information that you think is important that was not covered by the questions above? If so, please describe in detail – for example, can you think of any explanation for what is happening to you now? _____

_____

What worries you most about your current situation? _____

_____

Thank you very much for taking the time and attention to complete this questionnaire. We will discuss this information in an interview and it will be very helpful in your evaluation. Please be sure to bring it with you when you come for your appointment. You may feel free to make a copy for your records as well.