PATIENT INFORMATION FORM:

Date:_____

I. Identification data:

Full Name: _____

Sex: _____ DOB: _____ Age: _____

Primary Care Physician Name: _____ Phone: _____

Address: _____ Fax: _____

Person with legal custody (where applicable): _____

Address: _____ Phone: _____

Who referred you to our office? _____

Employer's name: _____

Occupation: _____

Are you currently applying for disability? _____ Family Medical Leave? _____

II. What problem concerns you? _____

_____

_____

_____

How long have these problems existed? _____

Have you sought previous help for these problems? _____

If yes, Name: _____ Address: _____ Phone: _____

Name: _____ Address: _____ Phone: _____

Do any of your other family members have learning, behavior or other problems? _____

If yes, Name: _____ Date: _____ Problem: _____

_____ Treatment: _____

MOOD

A. Do you have or have you ever had any episodes of the following:
(please circle)

Yes No 1. Feeling sad, down in the dumps or depressed

Yes No 2. Overly irritable

Yes No 3a. Loss`of interest in activities previously enjoyed?
Yes No 3b. Loss of ability to experience pleasure in activities previously enjoyed?

Yes No 4. Too much sleep

Yes No 5. Too little sleep

Yes No 5a. Difficulty falling asleep (requiring more than 30 min to fall asleep)

Yes No 5b. Difficulty staying asleep (awakening after falling asleep at night and being unable to fall asleep again in less than 30 min.)

Yes No 5c. Multiple times awakening with difficulty falling asleep (such that total sleep time is less than 7.5 hours)

Yes No 6. Becoming easily fatigued

Yes No 7. Excessive guilt

Yes No 8. Low self-esteem

Yes No 9. Impaired concentration

Yes No 10. Impaired decision-making

Yes No 11. Appetite loss

Yes No 12. Appetite increase

Yes No 13. Hopelessness or feeling like giving up on everything

Yes No 14. Thoughts of death or suicide

If yes, 14a. When was the most recent time that you had those thoughts?_____

Describe: _____

Yes No 15. Plans to harm yourself

Yes No 16. Plans to harm or kill others

If yes, 16a. When was the most recent time that you had those thoughts?_____

Describe: _____

If you answered yes to any of the items in section A: 1-8, did they cause problems in your social relationships / family _____, job_____, school performance _____

PLEASE READ ***EACH*** ITEM IN THIS SECTION ***COMPLETELY*** AND ***CAREFULLY BEFORE ANSWERING!***

B. Do you have periods of any of the following (please circle/check all that apply):

Yes No 1. ***ABNORMALLY*** happy or "high" moods so much that you react inappropriately to people or even cause people to react negatively or make comments about your behavior as strange or unusual. (not under the influence of drugs or alcohol)
If yes, check duration:___Everyday___Hours ___Days ___Weeks___Months

Yes No 2. Decreased need for sleep
___Everyday___Hours ___Days ___Weeks___Months___Years

Yes No 3. Being overly talkative
___Everyday___Hours ___Lifelong ___Limited periods of time

Yes No 4. Greatly increased energy or activity level
___Everyday___Hours ___Lifelong ___Limited periods of time

Yes No 5. Abnormally inflated self-esteem
___ Everyday ____Lifelong ____Days, weeks or months at a time

Yes No 6. High risk activities without serious thought of the consequences (e.g. overspending, increased sex drive, gambling, etc.)
____Everyday ____Lifelong ____ Days, weeks or months at a time

Yes No 7. A feeling that your thoughts are racing
____Everyday ____Lifelong ____Days, weeks or months at a time

Yes No 8. Being much more easily distracted than you normally are
____Everyday ____Lifelong ____Days, weeks or months at a time

If you answered yes to any of the items in section B: 1-8,

a. Did they cause problems in your: (Check all that apply)
Social/Family Relationships_____, Job _____, School Performance_____

C. Temperament: (please circle yes or no and feel free to describe any details in the margins)

Yes No 1. Do you perceive yourself or do others perceive you as being hyper?

Yes No 2. Do you make errors due to inattention to details or rushing through tasks?

Yes No 3. Do you have trouble paying attention, especially in reading or doing paper work material in which you have very little interest?

Yes No 4. Do people often notice that you appear not to listen when they are talking to you or giving you instructions?

Yes No 5. Do you often switch from one task or activity to another without finishing the first task or activity?

Yes No 6. Are you often disorganized?

Yes No 7. Do you often avoid or strongly dislike routine repetitive, or sedentary tasks (such as paper work, homework, reading textbooks, etc.)?

Yes No 8. Do you often misplace items necessary for school, work or personal use?

Yes No 9. Are you often distracted by extraneous stimuli / noise, movements?

Yes No 10. Are you often forgetful?

Yes No 11. Do you often fidget?

Yes No 12. Do you often leave your seat at inappropriate times?

Yes No 13. Do you feel restless?

Yes No 14. Do you often talk excessively?

Yes No 15. Do you often blurt out answers to questions before they are completed?

Yes No 16. Do you often interrupt people in conversation?

17. How old were you when you first had the above symptoms? _____

Yes No 18. Are you impatient in waiting?

D. Have you ever had any episodes of the following? (please circle)

Yes No 1. Discrete period(s) of intense fear or discomfort?

Yes No 2. Heart Palpitations (rapid pounding or irregular heartbeat)?

Yes No 3. Sweating?

Yes No 4. Tremors?

Yes No 5. Shortness of breath?

Yes No 6. A feeling of choking?

Yes No 7. Nausea or gastrointestinal distress?

Yes No 8. Dizziness

Yes No 9. Feelings of yourself or your surroundings as being unreal or that you are disconnected from your body?

Yes No 10. Fear of losing control of going crazy?

Yes No 11. Fear of Dying?

Yes No 12. Numbness?

Yes No 13. Chills or hot flashes?

Yes No 14. Constant Worrying?

Yes No 15. Avoidance of social occasions due to anxiety?

Yes No 16. Constantly keyed up or on edge?

Yes No 17. Excessive muscle tension?

Yes No 18. Difficulty sleeping due to anxiety or worry?

Yes No 19. Do you worry that you will have an episode of these symptoms?

_____ 20. How many times have any of these episodes occurred in the past month?

Yes No 21. Have you ever (at any age) been exposed to or witnessed a traumatic event (an event that threatened death or serious injury to you or others) which caused you to experience intense fear, horror or feelings of helplessness (such as being physically attacked, sexually assaulted, surviving a natural disaster, military combat, etc..)?

Yes No 22. Have you repeatedly re-experienced the traumatic event because of recurring unwanted memories of the trauma, nightmares of the trauma, acting or feeling that the traumatic experience was happening again?

Yes No 23. Do you feel intense emotional distress if you see, hear or feel something that reminds you of the traumatic event?

Yes No 24. Do you feel an intense physical reaction if you see, hear, or feel something That reminds you of the traumatic event?

Yes No 25. Do you try to avoid thoughts, feelings, or conversations associated with the traumatic event?

Yes No 26. Do you avoid activities, places, or people who remind you of the trauma?

Yes No 27. Are you unable to remember an important part of the trauma (such as times, places, faces, etc.)

Yes No 28. Do you feel detached or disconnected from people?

Yes No 29. Do you feel emotionally numb?

Yes No 30. Do you feel you won't live long enough to have a marriage, children, or a normal life span?

31. As a result of the trauma, have you experienced any of the following?

Yes No 31a. Difficulty falling asleep?

Yes No 31b. Irritability or anger outbursts?

Yes No 31c. Impaired concentration?

Yes No 31d. A feeling of being constantly on guard?

Yes No 31e. An abnormally high startle response (i.e. jumping more than the average person) when you hear a sudden unexpected sound or when someone surprises you?

32. If you answered yes to questions 21 through 31, how long have you had this emotional disturbance?

Less than one month _____, more than one month _____, more than 3 months_____

33. Have any of the symptoms you confirmed in questions 21 - 31 caused:

Yes No a. emotional distress?

Yes No b. interference with your ability to function?

Yes No c. problems at work?

Yes No d. problems in your social relationships/ marriage?

Yes No e. problems in school?

Yes No f. other?_____

Yes No 34. Have you repeatedly used avoidance of eating in order to lose weight or avoid gaining weight?

a. Date this began_____ Most recent occurrence date_____
b. How often ? _____times per day _____times per week
c. Resulting weight loss, if any _____lbs.
d. Resulting disturbances in menstrual periods? Yes_____ No_____

Yes No 35. Have you ever engaged in:
a.Date this began_____ Most recent occurrence date_____
b.How often ? _____times per day _____times per week
c.Resulting weight loss, if any _____lbs.
d.Resulting disturbances in menstrual periods? Yes_____ No_____

Yes No 35e. Are you spending a lot of time thinking about your body image?

Yes No 36. Do you ever have recurrent disturbing or unwanted thoughts that are foreign to your normal way of thinking?

Yes No 37. Do you have compulsive rituals (e.g. hand-washing, counting, checking, etc.)

Yes No 38. Do you ever see, hear, smell or feel things that other people do not?

39. Do you have beliefs that:

Yes No 39a. people are plotting against you?

Yes No 39b. people are talking about you behind your back?

Yes No 39c. people can read your mind or control your thoughts, or that you can do the same to others?

Yes No 40. Do you consume alcohol?

40a. How often? _____

40b. Average amount consumed in 24 hour period? _____

40c. Average amount consumed per week? _____

Yes No 40d. Have you ever had a DWI? _____

40e. Alcohol related: missed work _____, missed classes _____, lost job ____, loss of memory/ memory blackouts_____?

Yes No 40f. Has alcohol use caused Marital problems?

Yes No 41. Do you use any street drugs?
If yes, which one(s)? How often? Most recent date of use _____

Yes No 42. Do you smoke Cigarettes? Number of packs per day _____

Yes No 43. Have you had repeated medical problems or have a current physical illness?

Describe:_____

Yes No 44. Have you had any operations? _____

Yes No 45. Have you had any serious accidents or injuries (especially head injury)?

Describe:_____

Yes No 46. Have you been prescribed a medication for emotional problems?

Type: _____, Date: _____, Results: _____, Doctor: _____

Type: _____, Date: _____, Results: _____, Doctor: _____

Type: _____, Date: _____, Results: _____, Doctor: _____

Yes No 47. Have you ever had seizures or epilepsy? At what age? _____

Yes No 47a. If yes were you treated medically?

Yes No 47b. If yes are you still being treated?

III. Current Medications:

Type: _____ Date: _____, Doctor: _____, Results: _____

Type: _____ Date: _____, Doctor: _____, Results: _____

Type: _____ Date: _____, Doctor: _____, Results: _____

Type: _____ Date: _____, Doctor: _____, Results: _____

Yes No Allergies to medications? _____

IV. Family History- Has anyone in your family had the following:

Yes No Medical disease, such as diabetes, thyroid, or heart disease?

Yes No Mental illness, such as schizophrenia, manic-depression, depression?

Yes No Mental retardation?

Yes No Learning problems?

Yes No Behavior problems?

Yes No Excessive use of alcohol?

Yes No Excessive use of drugs?

Yes No Trouble with the law?

A. Family Relations:
Siblings (Please list full brothers and sisters only)
Name: Age: Sex:

Yes No Are your natural parents currently living together?

If no, What was the date of separation? _____ Patients age? _____

date of divorce? _____ Patients age? _____

Yes No Are your childhood memories generally pleasant?

B. Living Situation: With whom do you live? _____
_____
_____

Name: Age: Sex: Occupation (where applicable)

Yes No Are you currently married?

Yes No If so, does your present marriage dissatisfy you?

V. Education: Highest grade completed: _____

GPA: _____

Current occupation: _____

Military Service: _____

Yes No Does your present work situation dissatisfy you?

Describe: _____

VI. Diet: Please describe your current eating habits. _____
_____

Thank You, Dale J. Anderson, M.D.