Center for Emotional Fitness and Shore Therapy

This form is used **both** for an adult or child patient to fill out about **himself/herself**. It is also to be used by a parent, friend, teacher or guardian to **ask** a child all of these questions who does not/will not/cannot fill out form. Any child should bring 2-3 completed forms to the evaluation: One by/about the child and one by **each** parent.

NAME OF PERSON THIS FORM IS ABOUT: ____TODAY'S DATE: _____/_____/_____

AGE: __________ DATE OF BIRTH: _____/_____/_____ SOCIAL SECURITY #: ________________________

ADDRESS: ____

CITY: ____ STATE: _______ ZIP CODE: ____________________

TELEPHONE: _______________________ CELL PHONE: ___________________________EMAIL:__________________________

EMERGENCY CONTACT: _________________________________RELATIONSHIP: _______________TELEPHONE: ____________________

1. What kind of symptoms are you having (or why are you here)?

2. When did you first notice these symptoms?

3. What is the most important thing you want help with?

4. List all the medications you are supposed to take. (Medical or psychiatric) Include dosages and directions. Please list the effects these medications have on you. Please note if the medications are taken or not

7. Are you opposed to medications for you or your family member? YES NO
8. Please list all medications taken in the past that helped

9. Please list all medications taken in the past that did not help or caused a bad reaction. Please explain. Any medication may cause any side effect. Are you allergic to any medication or have you had any bad/unusual reactions to medication?

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10. Is there anyone in your family with any type of mental illness or psychiatric problems? YES NO
Who and what (diagnosed or undiagnosed) including parents, brothers, sisters, children, aunts, uncles, nephews, nieces & cousins

11. Is there any family history of drug or alcohol problems? (Diagnosed or undiagnosed) [including parents, brothers, sisters, children, aunts, uncles, nephews, nieces & cousins] YES NO ______________________

12. Have you ever had a psychiatric hospitalization? YES NO If so where? Please give details.

13. Are you now or have you ever been in psychiatric treatment? YES NO If so where? Please give details. __

14. Are you now or have you ever been in therapy or counseling? YES NO If so where? Please give details

15. How did prior treatments help or hurt you?

16. Have you ever been diagnosed with any specific medical problems? YES NO If so what? (Past and present)

17. Have you ever had any of the following? PMS Migraines TMJ Fibromyalgia Seizure Cancer Memory Loss
Problems with: Brain; muscles; nerves; Heart; Lungs; Kidney; Thyroid; Stomach/intestines; Endocrine; Aches/pains

18. Do you smoke cigarettes, cigars or chew tobacco? YES NO If so, which and how much? ____/day

19. Do you drink alcohol? YES NO If so, what do you drink? Is so how much? ____/day ____/week
Did you ever have a drinking problem? YES NO If so, how much were you drinking at the time? ____/day/week
When did you stop? _______________

20. Have you ever felt that you should cut down your drinking? YES NO

22. Have you ever felt bad or guilty about drinking? YES NO

23. Have you ever taken a drink 1st thing in the morning to steady your nerves or get rid of a hangover? YES NO

24. Do you gamble? (Atlantic City, football pool, bingo, lottery, etc.) YES NO
If so do you have gambling debts? YES NO How much now? ___________What is the most you ever lost?______

25. Have you ever been in a motor vehicle accident? YES NO Please give details. _________________

26. Have you ever had a head injury before? Were you unconscious? YES NO If so please explain in detail. _________

27. Have you had any other accidents (an assault, slip and fall, athletic, etc.) major or minor? YES NO
Please give details. How did it affect your life? ______________________________

28. Did you ever use street drugs? YES NO Which ones? ______________________________
How did they affect you? ______________________________

What is your drug(s) of choice______________________________

Do you use drugs now? YES NO __________ When did you last use? __________________________________

29. How much caffeine do you consume in a day? (coffee, tea, soda, energy drinks, etc.)

30. Have you ever been in trouble with the law? (juvenile or adult) YES NO
Please explain

31. What are your strengths?

32. What are your weaknesses?

33. How do you spend your average day?

34. What has been going on in your life in the past few months?

35. What kind of work do you do? Are you happy in this employ? YES NO
What kinds of jobs have you held in the past

36. Have you ever had surgery? YES NO If yes, what kind?

37. Have you ever been raped, molested, or physically or mentally abused? YES NO Please explain.

38. Do you like yourself? YES NO

39. Do you have a pet? YES NO What is your relationship with your pet?

40. What is the earliest memory of your childhood?

41. Tell me about your childhood, including school problems.

42. Tell me about your adolescence, including school problems.

43. Tell me about your adulthood.

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44. What is your relationship with your:

Mother: ______

Father: ______

Brother(s)/Sister(s): ______

Friends: ______

Spouse: ______

Children: ______

45. What sacrifices, if any, have you made for these people? ______

46. What sacrifices, if any, have they made for you? ______

47. Who do you live with? ______

48. Are there locks on your bathroom doors? YES NO Do people see each other naked in your home? YES NO

49. How did your parents' relationship affect you when you were younger? ______

50. How has it affected you through the years? ______

51. Do you have a best friend? YES NO Who is it and why? ______

52. How many years of schooling have you had? ______

53. Did you have any problem with school? Did anyone think that you had a learning disability? Were you classified in school? Were you in special education? ______

54. Do you have any problem with your interest in sexual relations, your performance sexually or your ability to achieve orgasms? Do you have an active sex life? Please describe: ______

55. Are you crying for no reason? YES NO Please describe: ______

56. Are you in physical pain? NO PAIN MILD PAIN MODERATE SEVERE PAIN EXCRUCIATING PAIN

i______ i______ i______i______i

0 1 2 3 4 5 6 7 8 9 10

57. What is the best thing that ever happened to you? ______

58. What is the worst thing that ever happened to you? ______

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59. Have you ever had a seizure? YES NO Explain: ____________________

60. Have you ever had an imaginary friend? YES NO Explain: ____________________

61. Do you snore? YES NO Do you stop breathing when you snore? YES NO

62. a. Do you wash your hands a lot, clean a lot or check things a lot? YES NO
    b. Do you think/worry a lot about things that make no sense YES NO
    c. Do your daily activities take a long time to finish YES NO

63. a. Are there any thoughts that keeps bothering you that you want to get rid of, but can't? YES NO
    b. Are you concerned about orderliness or symmetry? YES NO

64. Do you do things you don't remember doing? YES NO
    Do people tell you have done things that you are sure you haven't done? YES NO ____________________

65. What did you eat in the last 24 hours? ____________________

66. How do you feel about exercise? What do you do for exercise?____________________

67. How do you feel about your looks? ____________________

68. Do you have access to a gun? YES NO

69. Have you ever engaged in high risk behavior or thrill seeking that has a high potential for consequences (such as spending sprees, sexual indiscretion or promiscuity, foolish business investments or drug or alcohol abuse)? YES NO

Explain: ____________________

70. Are you religious? YES NO Please explain: ____________________

71. Do you have trouble falling asleep or trouble staying asleep because you have the urge to move your legs? YES NO

72. Have you ever felt very depressed? YES NO Now YES/NO Before the age of 20? YES/NO Before age 12? YES/NO

Please explain: ____________________

73. Do you feel suicidal now? YES NO Please explain: ____________________

74. Have you ever felt suicidal? YES NO Please explain: ____________________

75. Have you ever tried to kill yourself or purposely injured yourself or started to hurt, kill, or injure yourself? YES NO

Please explain ____________________

76. Do you often feel nervous, edgy, anxious, jittery, stressed out, concerned, worried, "what if this, what if that," even if you have a good reason to feel this way? YES NO Do you spend time thinking about the worst thing that could happen?
Please explain: ____________________

77. Have you ever felt nervous, edgy, anxious, jittery, stressed out, concerned, worried, "what if this, what if that," or spent a lot of time thinking about the worst thing that could happen even if you had a good reason to feel this way?
Please explain: ____________________

78. Do you or have you ever seen things that other people don't see? YES NO

Please explain: ____________________

79. Do you hear or have you ever heard voices when no one is in the room? YES NO

Please explain: ____________________

80. Has your mind ever played tricks on you? YES NO

Please explain: ____________________

81. Has your brain ever held a conversation over which you had no control? YES NO

Please explain: ____________________

Can people put thoughts into your head or take thoughts out? YES NO

Please explain ____________________

Can people read your mind or can you read their minds? YES NO

Please explain ____________________

82. Is anyone trying to hurt or harm you now or in the past? YES NO

Please explain ____________________

83. Do you have nightmares? YES NO

Please explain ____________________

84. Do you now or have you ever, ever, ever™ felt too happy? YES NO

Please explain ____________________

____

85. Do you now or have you ever, ever, ever™ felt too giddy, too elated or too full of? YES NO

Please explain ____________________

____

86. Do you now or have you ever, ever, ever™ felt too angry? YES NO

Please explain ____________________

87. Do you now or have you ever felt too sexy? YES NO Please explain ____________________

____

88. Do you have any habits such as twitches, eye blinks, coughing, clearing your throat or any other rituals over which you have little or no control? YES NO
Please explain ____________________

89. Do you now or have you ever had racing thoughts (thoughts racing so fast in your head that you can't keep up with them? YES NO Please explain ____________________

____

90. Are you a procrastinator? YES NO Please explain ____________________

91. Do you now or have you ever felt that people are against you? Do you now or have you ever felt paranoid?

YES NO Please explain ____________________

92. Do people consider you disagreeable? YES NO Do you consider yourself disagreeable? YES NO
93. Do people consider you irritable? YES NO Do you consider yourself irritable? YES NO
94. Do people consider you impatient? YES NO Do you consider yourself impatient? YES NO
95. Do people consider you argumentative? YES NO Do you consider yourself argumentative? YES NO
96. Do people consider you angry? YES NO Do you consider yourself angry? YES NO

97. Are your moods predictable, for instance, when you go to bed at night do you know what mood you will be in when you wake up in the morning because your moods are always the same? YES NO Please explain ____________________

____

____

98. **ADHD checklist. (Attention-Deficit/Hyperactivity Disorder)** Do you have the following now or did you as a child?

☐Now ☐In the past ☐Never	1. Often fail to give close attention to details or make careless mistakes in schoolwork, work or other activities
☐Now ☐In the past ☐Never	2. Often have difficulty sustaining attention in tasks or play activities
☐Now ☐In the past ☐Never	3. Often do not seem to listen when spoken to directly
☐Now ☐In the past ☐Never	4. Often do not follow through on instructions and fails to finish schoolwork, chores, or duties in the
☐Now ☐In the past ☐Never	5 Often have difficulty organizing tasks and activities
☐Now ☐In the past ☐Never	6. Often avoid, dislike or are reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)
☐Now ☐In the past ☐Never	7. Often lose things for tasks or activities (e.g., toys, school assignments, pencils, books or tools)
☐Now ☐In the past ☐Never	8. Often easily distracted by extraneous stimuli (sounds, smells, lights, activity)
☐Now ☐In the past ☐Never	9. Often forgetful in daily activities (although these things are done over and over again)
☐Now ☐In the past ☐Never	10. Often fidget with hands or feet or squirm in seat
☐Now ☐In the past ☐Never	11. Often leave seat in classroom or other situations in which remaining seated is expected
☐Now ☐In the past ☐Never	12. Often run about or climb excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness)
☐Now ☐In the past ☐Never	13. Often have difficulty playing or engaging in leisure activities quietly
☐Now ☐In the past ☐Never	14. Often “on the go” or often act as if “driven by a motor”
☐Now ☐In the past ☐Never	15. Often talk excessively (talks too much; trouble getting to the point
☐Now ☐In the past ☐Never	16. Often blurt out answers before questions have been completed
☐Now ☐In the past ☐Never	17. Often have difficulty awaiting turn
☐Now ☐In the past ☐Never	18. Often interrupt or intrude on others (e.g., butt into conversations or games)

99. **SPIN (SOCIAL PHOBIA INVENTORY**)

	Not at all 0	A little bit 1	Somewhat 2	Very much 3	Extremely 4
1. I am afraid of people in authority.	☐	☐	☐	☐	☐
2. I am bothered by blushing in front of people.	☐	☐	☐	☐	☐
3. Parties and social events scare me.	☐	☐	☐	☐	☐
4. I avoid talking to people I don’t know	☐	☐	☐	☐	☐
5. Being criticized scares me a lot	☐	☐	☐	☐	☐
6. Fear of embarrassment cause me to avoid doing things or speaking to people.	☐	☐	☐	☐	☐
7. Sweating in front of people causes me distress.	☐	☐	☐	☐	☐
8. I avoid going to parties.	☐	☐	☐	☐	☐
9. I avoid activities in which I am the center of attention	☐	☐	☐	☐	☐
10. Talking to strangers scares me.	☐	☐	☐	☐	☐
11. I avoid having to give speeches	☐	☐	☐	☐	☐
12. I would do anything to avoid being criticized	☐	☐	☐	☐	☐
13. Heart palpitations bother me when I am around people	☐	☐	☐	☐	☐
14. I am afraid of doing things when people might be watching	☐	☐	☐	☐	☐
15. Being embarrassed or looking stupid are among my worse fears.	☐	☐	☐	☐	☐
16. I avoid speaking to anyone in authority	☐	☐	☐	☐	☐
17. Trembling or shaking in front of others is distressing to me	☐	☐	☐	☐	☐

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PLEASE ADD UP YOUR TOTAL SCORE __________

100. **PANIC ATTACK AND ANXIETY ATTACK QUESTIONAIRRE**

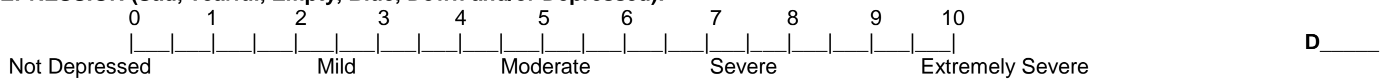
1. Do you have panic attacks or anxiety attacks out of the blue? YES NO
2. Do they develop abruptly and reach a peak in within 10 minutes? YES NO
3. Do you have the following symptoms with these attacks (check all that apply)?

___ **S**hortness of breath/smothering sensations
___ **U**nreality feelings (Derealization or Depersonalization)
___ **D**ying is feared
___ **D**iscomfort in the chest or chest pain
___ **E**vidence of trembling or shaking
___ **N**umbness or tingling sensations (paresthesias)
___ **L**ightheaded, dizzy, unsteady or faint
___ **S**weating
___ **C**hills or hot flushes
___ **A**bdominal distress or nausea
___ **R**apid heart beat, palpitations or pounding heart
___ **Y**ou feel you are choking
___ **Y**ou fear you are losing control or going crazy

101. DISGUSTED SCALE©

On each scale from 0 to 10, please CIRCLE the number that best expresses each symptom over the past week:
On each scale from 0 to 10, please X over the number that matches how you felt on the worst week in your life:

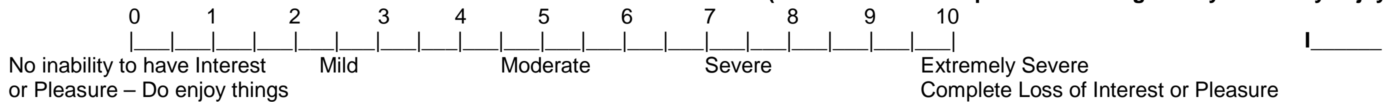
DEPRESSION (Sad, Tearful, Empty, Blue, Down and/or Depressed):



Not Depressed | Mild | Moderate | Severe | Extremely Severe

D_____

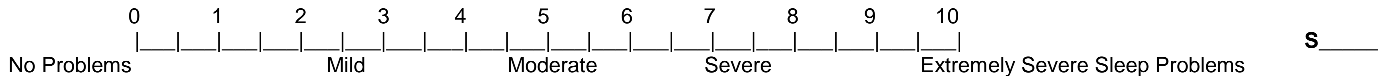
INABILILITY TO ENJOY OR HAVE INTEREST AND PLEASURE IN ACTIVITIES (LOSS of Interest or pleasure in things that you usually enjoy):



No inability to have Interest or Pleasure – Do enjoy things | Mild | Moderate | Severe | Extremely Severe Complete Loss of Interest or Pleasure

I______

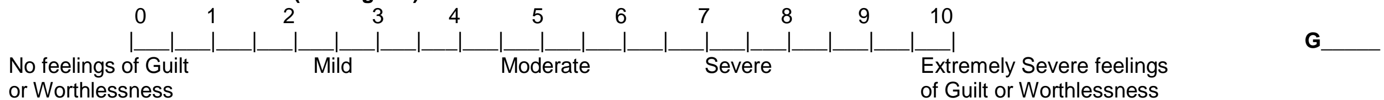
SLEEP PROBLEMS:



No Problems | Mild | Moderate | Severe | Extremely Severe Sleep Problems

S_____

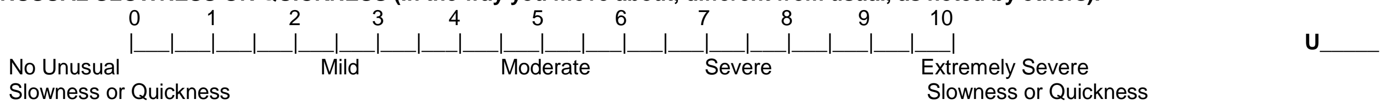
GUILT OR WORTHLESSNESS (Feelings of):



No feelings of Guilt or Worthlessness | Mild | Moderate | Severe | Extremely Severe feelings of Guilt or Worthlessness

G_____

UNUSUAL SLOWNESS OR QUICKNESS (In the way you move about, different from usual, as noted by others):



No Unusual Slowness or Quickness | Mild | Moderate | Severe | Extremely Severe Slowness or Quickness

U_____

SUICIDAL ATTEMPTS, PLANS OR THOUGHTS OR THOUGHTS OF DEATH (Not just fear of dying):

Not Suicidal & No Thoughts of Death | Mild | Moderate | Severe | Severe Thoughts of Suicide or Death

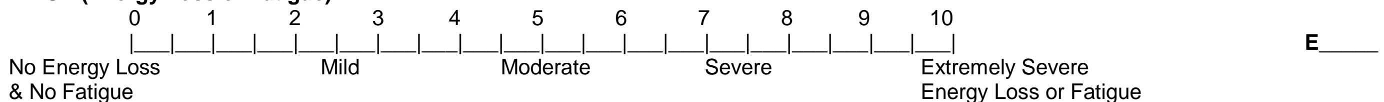
S_____

THINKING PROBLEMS (Concentration Loss or Indecisiveness):

No Concentration Loss or Indecisiveness | Mild | Moderate | Severe | Extremely Severe Concentration Loss or Indecisiveness

T_____

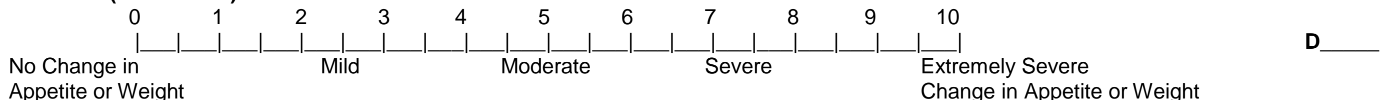
ENERGY (Energy Loss or Fatigue):



No Energy Loss & No Fatigue | Mild | Moderate | Severe | Extremely Severe Energy Loss or Fatigue

E_____

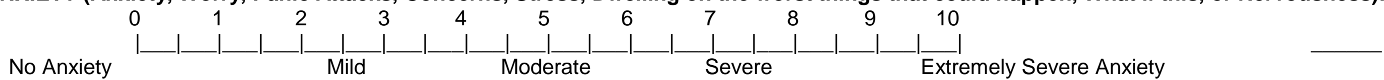
DECREASE (or increase) IN APPETITE OR WEIGHT:



No Change in Appetite or Weight | Mild | Moderate | Severe | Extremely Severe Change in Appetite or Weight

D_____

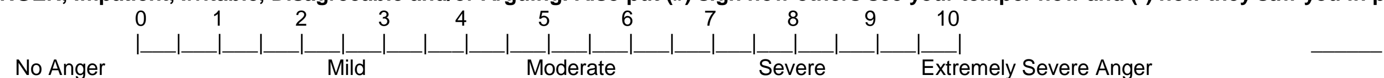
ANXIETY (Anxiety, Worry, Panic Attacks, Concerns, Stress, Dwelling on the worst things that could happen, What if this, or Nervousness):



No Anxiety | Mild | Moderate | Severe | Extremely Severe Anxiety

______

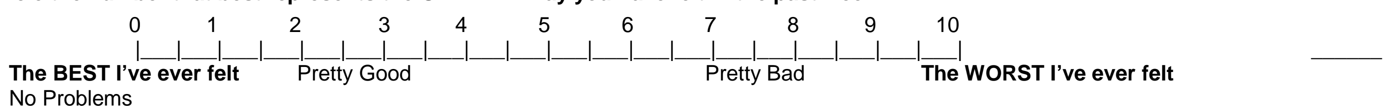
ANGER, Impatient, Irritable, Disagreeable and/or Arguing. Also put (#) sign how others see your temper now and (*) how they saw you in past.



No Anger | Mild | Moderate | Severe | Extremely Severe Anger

______

Circle the number that best represents the OVERALL way you have felt in the past week.



The BEST I've ever felt No Problems | Pretty Good | Pretty Bad | **The WORST I've ever felt**

______

When was the best you ever felt and why? ______________________________

When was the worst you ever felt and why?______________________________

If there is anything of concern or interest that was not on this form, please write about it here and make sure it is discussed

____

____

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