Center for Emotional Fitness

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

PATIENT'S NAME: _____ **TODAY'S DATE**: ____/_____/_____

DATE OF BIRTH: _____/_____/_____ **AGE**: _____ **GENDER**: _____ **SOCIAL SECURITY #** _____

ADDRESS:_____

CITY: _____ **STATE**: _____ **ZIP CODE**: _____

HOME PHONE: _____ **CELL PHONE:** _____ **EMAIL**: _____

EMERGENCY CONTACT: _____ **RELATIONSHIP**: _____ **PHONE**: _____

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. Are you allergic to any medications? Yes No If so, what? _____

5. Are you opposed to medications for yourself or your family member? Yes No If yes, why? _____

6. List all the medications you are supposed to take (medical, psychiatric, OTC). Include dosages and directions. List the effects of each medication, positive and/or negative. Indicate if medication is taken as directed.

7. List all medications taken in the past that helped. _____

8. List all medications taken in the past that caused a bad reaction or did not help. Please give details.

9. Is there anyone in your family with any type of mental illness or psychiatric problems? Yes No
If yes, who and what (diagnosed or undiagnosed) including parents, grandparents, brothers, sisters, children, aunts, uncles, nephews, nieces, cousins

10. Is there any family history of drug or alcohol problems? Yes No
    If yes, who and what (diagnosed or undiagnosed) including parents, grandparents, brothers, sisters, children, aunts, uncles, nephews, nieces, cousins

11. Have you ever been hospitalized for a psychiatric/mental health issue? Yes No
    If yes, where and when? Please give details.

12. Are you now or have you ever been in psychiatric/mental health treatment (including psychotherapy/counseling)
    Yes No If yes, where and when? Please give details.

13. How did prior treatments help or hurt you?

14. Have you ever been diagnosed with any medical problems? Yes No
    If yes, what? Please give details.

15. Have you ever had any of the following? PMS Migraines TMJ Fibromyalgia Seizures Cancer
    Memory Loss Sleep Apnea Chronic Pain Trauma
    Do you have problems with your: Brain Muscles Nerves Heart Lungs Kidneys Thyroid
    Stomach/intestines Endocrine System

16. Do you use nicotine products (smoke cigarettes, cigars, vape, or chew tobacco)? Yes No
    If yes, what, how often?

17. Do you drink alcohol? Yes No
    If yes, what do you drink? _____ How much? _____/day _____/week
    Has drinking alcohol ever caused any problems for you? Yes No
    Have you ever stopped drinking because of problems? Yes No
    Have you ever felt that you should cut down your drinking? Yes No
    Has anyone ever criticized your drinking? Yes No
    Have you ever felt bad or guilty about drinking? Yes No
    Have you ever taken a drink 1st thing in the morning? Yes No
    Have you ever felt shaky or had tremors when you didn't drink alcohol? Yes No
    Give details: _____

18. Do you or have you ever used illicit substances/street drugs? Yes No
    What do you or have you used? _____
    How do/did drug(s) affect you? _____
    What is/was your drug(s) of choice? _____
    Do you use drugs now? Yes No When did you last use? _____

19. Do you use caffeine? (coffee, tea, soda, energy drinks, caffeine pills, etc.) Yes No
    If yes, what, how much? _____

20. Do you gamble? (casinos, sports, bingo, lottery, etc.) Yes No
    If yes, do you have gambling debts? Yes No
    How much? _____ What is the most you ever lost? _____

21. Have you ever been in a motor vehicle accident? Yes No
    If yes, please give details _____

22. Have you ever had a head injury? Yes No Were you unconscious? Yes No
    If yes, please give details _____

23. Have you had any other accidents/injuries (an assault, slip and fall, athletic, etc.) major or minor? Yes No
If yes, please give details _____

24. Have you ever been in trouble with the law? (as a juvenile or adult) Yes No
If yes, please explain _____

25. What are your strengths? _____

26. What are your weaknesses? _____

27. How do you spend your average day? _____

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

29. What kind of work do you do? _____
Do you like your job? Yes No
What kinds of jobs have you held in the past _____

30. Have you ever had surgery? Yes No If yes, what kind, when? _____

31. Have you ever been raped, molested, or physically or mentally abused? Yes No
If yes, please give details _____

32. Do you like yourself? Yes No Why or why not? _____

33. What is the earliest memory of your childhood? _____

34. Tell me about your childhood, including how you did in school, were you classified, in special ed, did you have learning disabilities? _____

35. Tell me about your adolescence, including how you did in school, were you classified, in special ed, did you have learning disabilities? _____

36. How many years of schooling have you had? _____

37. Tell me about your adulthood _____

38. How is your relationship with your:
Mother: _____
Father: _____
Brother(s)/Sister(s): _____
Spouse: _____
Children: _____
Friends: _____

39. What sacrifices, if any, have you made for these people? _____

40. What sacrifices, if any, have they made for you? _____

41. Do you have a pet? Yes No How is your relationship with your pet? _____

42. Who do you live with? _____

43. Are there locks on your bathroom doors? Yes No Do people see each other naked in your home? Yes No

44. How did your parents' relationship affect you when you were younger? _____

45. How has your parents' relationship affected you over the years? _____

46. Do you have a best friend? Yes No Who is it and why do you consider them a good friend? _____

47. Do you have any problems with your interest in sexual relations, your performance sexually or your ability to achieve orgasms? Do you have an active sex life? _____

48. Do you cry for no reason? Yes No If yes, please give details _____

49. Do you have physical pain?

No Pain		Mild		Moderate		Severe		Excruciating	
0	1	2	3	4	5	6	7	8	9	10

50. What is the best thing that ever happened to you? _____

51. What is the worst thing that ever happened to you? _____

52. Have you ever had a seizure? Yes No If yes, please give details _____

53. Have you ever had an imaginary friend? Yes No If yes, please give details: _____

54. Do you snore? Yes No Has anyone ever said you stop breathing when you sleep? Yes No

55. 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

56. a. Do you have thoughts that bother you, that you wish you could stop, but can't? Yes No
    b. Are you concerned about order and/or symmetry? Yes No

57. Do you do things you don't remember or have others told you have done things you don't remember? Yes No

58. What did you eat in the last 24 hours? _____

59. How do you feel about exercise? What do you do for exercise? _____

60. How do you feel about your looks? _____

61. Do you have access to a gun? Yes No Is it kept safely secured? Yes No

62. Have you ever engaged in high-risk behavior or thrill seeking that has a high potential for consequences (such as spending sprees, sexual indiscretions or promiscuity, foolish business investments, substance abuse, etc.)? Yes No If yes, please give details _____

63. Are you religious, spiritual, or do you believe in a higher power? Yes No

64. Do you have trouble falling asleep or trouble staying asleep? Yes No

65. Have you ever felt depressed? Yes No
Ever depressed before age of 20? Yes No
Before age 12? Yes No
Are you depressed now? Yes No
If yes,to any, please give details _____

66. Do you feel suicidal now? Yes No If yes, please give details _____

67. Have you ever felt suicidal? Yes No If yes, please give details _____

68. Have you ever tried to kill yourself or purposely injured yourself or started to hurt, kill, or injure yourself? Yes No
If yes, please give details _____

69. Do you often feel or have you ever felt 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? If yes, please give details _____

70. Do you or have you ever seen things that other people don't see? Yes No
If yes, please give details _____

71. Do you hear or have you ever heard voices when no one is in the room? Yes No
If yes, please give details _____

72. Has your mind ever played tricks on you? Yes No
If yes, please give details _____

73. Has your brain ever held a conversation over which you had no control? Yes No
If yes, please give details _____
Can people put thoughts into your head or take thoughts out? Yes No
If yes, please give details _____
Can people read your mind or can you read their minds? Yes No
If yes, please give details _____

74. Is anyone trying to hurt or harm you now or has anyone hurt you in the past? Yes No
If yes, please give details _____

75. Do you have nightmares? Yes No
If yes, please give details _____

76. Do you now or have you ever, ever, ever™ felt too happy? Yes No
If yes, please give details _____

77. Do you now or have you ever, ever, ever™ felt too giddy, too elated or too full of yourself? Yes No
If yes, please give details _____

78. Do you now or have you ever, ever, ever™ felt too angry? Yes No
If yes, please give details _____

79. Do you now or have you ever felt too sexy? Yes No
If yes, please give details _____

80. 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 If yes, please give details _____

81. 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 If yes, please give details _____

82. Are you a procrastinator? Yes No If yes, please give details _____

83. Do you now or have you ever felt paranoid or felt that people were against you? Yes No If yes, please give details _____

84. Do people consider you disagreeable?	Yes	No	Do you consider yourself disagreeable?	Yes	No
85. Do people consider you irritable?	Yes	No	Do you consider yourself irritable?	Yes	No
86. Do people consider you impatient?	Yes	No	Do you consider yourself impatient?	Yes	No
87. Do people consider you argumentative?	Yes	No	Do you consider yourself argumentative?	Yes	No
88. Do people consider you angry?	Yes	No	Do you consider yourself angry?	Yes	No

89. 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
If yes, please give details _____

90. **ADHD checklist. (Attention-Deficit/Hyperactivity Disorder)** Circle **all** that apply:

a. Often fail to give close attention to details or make careless mistakes in schoolwork, work or other activities Never In the past Now Always

b. Often have difficulty sustaining attention in tasks or play activities Never In the past Now Always

c. Often do not seem to listen when spoken to directly Never In the past Now Always

d. Often do not follow through on instructions and fails to finish schoolwork, chores, or duties Never In the past Now Always

e. Often have difficulty organizing tasks and activities Never In the past Now Always

f. Often avoid, dislike or are reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework) Never In the past Now Always

g. Often lose things for tasks and activities (e.g., toys, school assignments, pencils, books, tools) Never In the past Now Always

h. Often easily distracted by extraneous stimuli (sounds, smells, lights, activity) Never In the past Now Always

i. Often forgetful in daily activities (although these things are done over and over again) Never In the past Now Always

j. Often fidget with hands or feet or squirm in seat Never In the past Now Always

k. Often leave seat in classroom or other situations in which remaining seated is expected Never In the past Now Always

l. Often run about or climb excessively in situations in which it is inappropriate (in adolescents and adults, may be limited to subjective feelings of restlessness) Never In the past Now Always

m. Often have difficulty playing or engaging in leisure activities quietly Never In the past Now Always

n. Often "on the go" or often act as if "driven by a motor" Never In the past Now Always

o. Often talk excessively (talks too much; trouble getting to the point) Never In the past Now Always

p. Often blurts out answers before questions have been completed Never In the past Now Always

q. Often have difficulty awaiting turn Never In the past Now Always

r. Often interrupt or intrude on others (e.g., butt into conversations or games) Never In the past Now Always

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

	Not at all 0	A little bit 1	Somewhat 2	Very much 3	Extremely 4
a. I am afraid of people in authority	☐	☐	☐	☐	☐
b. I am bothered by blushing in front of people	☐	☐	☐	☐	☐
c. Parties and social events scare me.	☐	☐	☐	☐	☐
d. I avoid talking to people I don't know	☐	☐	☐	☐	☐
e. Being criticized scares me a lot	☐	☐	☐	☐	☐
f. Fear of embarrassment causes me to avoid doing things or speaking to people	☐	☐	☐	☐	☐
g. Sweating in front of people causes me distress	☐	☐	☐	☐	☐
h. I avoid going to parties	☐	☐	☐	☐	☐
i. I avoid activities in which I am the center of attention	☐	☐	☐	☐	☐
j. Talking to strangers scares me	☐	☐	☐	☐	☐
k. I avoid having to give speeches	☐	☐	☐	☐	☐
l. I would do anything to avoid being criticized	☐	☐	☐	☐	☐
m. Heart palpitations bother me when I am around people	☐	☐	☐	☐	☐
n. I am afraid of doing things when people might be watching	☐	☐	☐	☐	☐
o. Being embarrassed/looking stupid are among my worst fears	☐	☐	☐	☐	☐
p. I avoid speaking to anyone in authority	☐	☐	☐	☐	☐
q. Trembling or shaking in front of others is distressing to me	☐	☐	☐	☐	☐

PLEASE ADD UP YOUR TOTAL SCORE _____

92. **PANIC ATTACK AND ANXIETY ATTACK QUESTIONAIRRE**

a. Do you have panic attacks or anxiety attacks out of the blue? Yes No
b. Do they develop abruptly and reach a peak within 10 minutes? Yes No
c. Do you have any of 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 (paresthesia)
___ **L**ightheaded, dizzy, unsteady or faint
___ **Y**ou fear you are losing control or going crazy
___ **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

93. **CIRCLE BELOW - how often you have had each symptom <u>over the past 7 days</u>**

0% is not even once over the past 7 days
1-19% is rarely over the past 7 days
20 -39% is more than rarely but less than half the time
40- 59% is about half the time
60 -79% is more than half the time but less than most of the time
80 -99% is most of the time but not all the time
100% is all of the time the past 7days

Depressed / sad / tearful / empty	0%	1%-19%	20%-39%	40%-59%	60%-79%	80%-99%	100%
Interest is low / loss of pleasure in things	0%	1%-19%	20%-39%	40%-59%	60%-79%	80%-99%	100%
Sleep disturbance	0%	1%-19%	20%-39%	40%-59%	60%-79%	80%-99%	100%
Guilty or worthless	0%	1%-19%	20%-39%	40%-59%	60%-79%	80%-99%	100%
Unusually slow or quick moving vs. normal	0%	1%-19%	20%-39%	40%-59%	60%-79%	80%-99%	100%
Suicidal thoughts, ideas, acts or focus	0%	1%-19%	20%-39%	40%-59%	60%-79%	80%-99%	100%

Thinking / concentration / attention problems	0%	1%-19%	20%-39%	40%-59%	60%-79%	80%-99%	100%
Energy is low	0%	1%-19%	20%-39%	40%-59%	60%-79%	80%-99%	100%
Decreased or increased appetite	0%	1%-19%	20%-39%	40%-59%	60%-79%	80%-99%	100%
Felt glad to be alive	0%	1%-19%	20%-39%	40%-59%	60%-79%	80%-99%	100%
Anxiety/worry/fear/nervous/stress/ "what ifs"	0%	1%-19%	20%-39%	40%-59%	60%-79%	80%-99%	100%
Pain	0%	1%-19%	20%-39%	40%-59%	60%-79%	80%-99%	100%
Angry / irritable / disagreeable / bitchy	0%	1%-19%	20%-39%	40%-59%	60%-79%	80%-99%	100%
Too happy/ elated / excited / too full of self/ manic	0%	1%-19%	20%-39%	40%-59%	60%-79%	80%-99%	100%
High goal-directed activity or high energy level	0%	1%-19%	20%-39%	40%-59%	60%-79%	80%-99%	100%
Racing thoughts or flight of ideas	0%	1%-19%	20%-39%	40%-59%	60%-79%	80%-99%	100%
Talking more or faster than usual	0%	1%-19%	20%-39%	40%-59%	60%-79%	80%-99%	100%
Sleeping very little but not feeling tired	0%	1%-19%	20%-39%	40%-59%	60%-79%	80%-99%	100%
Inflated self-esteem or grandiosity	0%	1%-19%	20%-39%	40%-59%	60%-79%	80%-99%	100%
Engaging in dangerous/expensive/foolishness	0%	1%-19%	20%-39%	40%-59%	60%-79%	80%-99%	100%
Hallucinations-seeing or hearing things not there	0%	1%-19%	20%-39%	40%-59%	60%-79%	80%-99%	100%
Paranoia / suspiciousness / delusions	0%	1%-19%	20%-39%	40%-59%	60%-79%	80%-99%	100%
Panic / Panic attacks / Anxiety attacks	0%	1%-19%	20%-39%	40%-59%	60%-79%	80%-99%	100%
Shyness / Fear of embarrassment socially	0%	1%-19%	20%-39%	40%-59%	60%-79%	80%-99%	100%
Counting / checking / washing / ordering /OCD	0%	1%-19%	20%-39%	40%-59%	60%-79%	80%-99%	100%
Muscle Tension / Muscle Tightness	0%	1%-19%	20%-39%	40%-59%	60%-79%	80%-99%	100%

In the past 7 days, how many times **per day** did you use nicotine products (cigarettes, chew tobacco, vape, etc.)?	0	1-5	6-10	11-15	16-20	21-30	31+
In the past 7 days, how many **days** did you drink alcohol?	1	2	3	4	5	6	7
In the past 7 days, **in total**, how many alcoholic drinks did you have?	0	1-5	6-10	11-15	16-20	21-30	31+

In the past 7 days rate yourself on the **Sad to Happy Scale** ©	saddest ever -6	-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5	happiest ever +6

In the past 7 days rate your overall functioning ©	worst ever -6	-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5	best ever +6

Over the past 7 days have you been glad to be alive? ©	not at all 0	1	2	3	4	5	extremely 6

Over the past 7 days, what was your level of motivation, drive, ambition, initiative? ©	none at all 0	1	2	3	4	5	maximum 6