Center for Emotional Fitness and Shore Therapy

This form is used **both** for an adult patient or child patient to fill out about **himself/herself**. It is also used by a parent, friend, teacher or guardian who needs to **ask** a child all of these questions who 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

5. Are you opposed to medications for yourself or your family member? YES NO
6. Please list all medications taken in the past that helped _____

7. Are you allergic to any medications? YES NO

8. Please list all medications taken in the past that caused a bad reaction or did not help. Please explain. Any medication may cause a side effect.

9. 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

10. 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

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

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

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

14. How did prior treatments help or hurt you?

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

16. 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

17. Do you smoke cigarettes, cigars or chew tobacco? YES NO If so, which and how much? ____/day
18. Do you drink alcohol? YES NO If so, what do you drink? 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? _____
19. Have you ever felt that you should cut down your drinking? YES NO
20. Has anyone ever criticized your drinking? YES NO
21. Have you ever felt bad or guilty about drinking? YES NO
22. Have you ever taken a drink 1st thing in the morning to steady your nerves or get rid of a hangover? YES NO
23. 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?_____
24. Have you ever been in a motor vehicle accident? YES NO Please give details.

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

26. 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?

27. Did you ever use street drugs? YES NO Which ones?
A/ How did they affect you?

B/ What is your drug(s) of choice

C/ Do you use drugs now? YES NO _____ When did you last use? _____

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

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

30. What are your strengths?

31. What are your weaknesses?

32. How do you spend your average day?

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

34. 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

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

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

37. Do you like yourself? YES NO

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

39. What is the earliest memory of your childhood?

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

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

42. Tell me about your adulthood.

43. What is your relationship with your:
Mother: _____

Father: _____

Brother(s)/Sister(s): _____

Friends: _____

Spouse: _____

Children: _____

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

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

46. Who do you live with? _____

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

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

49. How has it affected you through the years? _____

50. Do you have a best friend? YES NO Who is it and why? _____

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

52. 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? _____

53. 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: _____

54. Are you crying for no reason? YES NO Please describe: _____

55. Are you in physical pain?

NO PAIN		MILD PAIN		MODERATE		SEVERE PAIN		EXCRUCIATING PAIN	
i_____		i_____		i_____		i_____		i_____	i
0	1	2	3	4	5	6	7	8	9	10

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

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

58. Have you ever had a seizure? YES NO Explain: _____

59. Have you ever had an imaginary friend? YES NO Explain: _____

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

61. 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

62. 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

63. 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 _____

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

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

66. How do you feel about your looks? _____

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

68. 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: _____

69. Are you religious? YES NO Please explain: _____

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

71. 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: _____

72. Do you feel suicidal now? YES NO Please explain: _____

73. Have you ever felt suicidal? YES NO Please explain: _____

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

Please explain _____

75. 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: _____

76. 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: _____

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

Please explain: _____

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

Please explain: _____

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

Please explain: _____

80. 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 _____

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

Please explain _____

82. Do you have nightmares? YES NO

Please explain _____

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

Please explain _____

_____

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

Please explain _____

_____

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

Please explain _____

86. Do you now or have you ever felt too sexy? YES NO Please explain _____

_____

87. 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 _____

88. 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 _____

_____

89. Are you a procrastinator? YES NO Please explain _____

90. 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 _____

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

96. 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 _____

_____

_____

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

☐Now ☐In the past ☐Never ☐ Always 1. Often fail to give close attention to details or make careless mistakes in schoolwork, work or other activities

☐Now ☐In the past ☐Never ☐ Always 2. Often have difficulty sustaining attention in tasks or play activities

☐Now ☐In the past ☐Never ☐ Always 3. Often do not seem to listen when spoken to directly

☐Now ☐In the past ☐Never ☐ Always 4. Often do not follow through on instructions and fails to finish schoolwork, chores, or duties

☐Now ☐In the past ☐Never ☐ Always 5. Often have difficulty organizing tasks and activities

☐Now ☐In the past ☐Never ☐ Always 6. Often avoid, dislike or are reluctant to engage in tasks that require sustained mental effort (such as schoolwork of homework)

☐Now ☐In the past ☐Never ☐ Always 7. Often lose things for tasks or activities (e.g., toys, school assignments, pencils, books tools)

☐Now ☐In the past ☐Never ☐ Always 8. Often easily distracted by extraneous stimuli (sounds, smells, lights, activity)

☐Now ☐In the past ☐Never ☐ Always 9. Often forgetful in daily activities (although these things are done over and over again)

☐Now ☐In the past ☐Never ☐ Always 10. Often fidget with hands or feet or squirm in seat

☐Now ☐In the past ☐Never ☐ Always 11. Often leave seat in classroom or other situations in which remaining seated is expected

☐Now ☐In the past ☐Never ☐ Always 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 ☐ Always 13. Often have difficulty playing or engaging in leisure activities quietly

☐Now ☐In the past ☐Never ☐ Always 14. Often "on the go" or often act as if "driven by a motor"

☐Now ☐In the past ☐Never ☐ Always 15. Often talk excessively (talks too much; trouble getting to the point

☐Now ☐In the past ☐Never ☐ Always 16. Often blurt out answers before questions have been completed

☐Now ☐In the past ☐Never ☐ Always 17. Often have difficulty awaiting turn

☐Now ☐In the past ☐Never ☐ Always 18.Often interrupt or intrude on others (e.g., butt into conversations or games)

98. **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/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	☐	☐	☐	☐	☐

PLEASE ADD UP YOUR TOTAL SCORE _____

99. **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 (paresthesia)
___ **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

100. CIRCLE BELOW - Ɵ - how often you have had each symptom over the last 7 days

0% is not even once over the last 7 days; 1-19% is rarely; 20 -39% is more than rarely but less than half; 40-59% is half the time last week
60 -79% is more than 1/2 but less than most; 80 -99% is most but not all the time over the last 7 days; 100% is all the time the last 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%
Loss of motivation, drive, ambition, initiative	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%
Angry / irritable / disagreeable / bitchy	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%
Too happy / elated / excited / too full of self	0%	1%-19%	20%-39%	40%-59%	60%-79%	80%-99%	100%
More distracted than usual	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%
High activity level / cannot sit still / interrupting	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%
Cigarette smoking daily	0	1 to 5	6 to 10	11 to 15	16 to 20	21 to 30	31+
Alcohol Use over last week. Number of drinks	0	1 to 5	6 to 10	11 to 15	16 to 20	21 to 30	31+
Happy - Sad Scale (Please circle from +6 to -6)	happiest ever +6	+5	+4	+3	+2	+1	0 -1 -2 -3 -4 -5 -6 saddest ever
Overall functioning (Please circle from +6 to -6)	best ever +6	+5	+4	+3	+2	+1	0 -1 -2 -3 -4 -5 -6 worst ever
How would you rate your depression this week?	None	Mild	Mild-Moderate	Moderate	Moderate-Severe	Severe	Extreme