

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

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PLEASE ADD UP YOUR TOTAL SCORE _____

99. PANIC ATTACK AND ANXIETY ATTACK QUESTIONAIRE

- 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)?
 - Shortness of breath/smothering sensations Sweating
 - Unreality feelings (Derealization or Depersonalization) Chills or hot flushes
 - Dying is feared Abdominal distress or nausea
 - Discomfort in the chest or chest pain Rapid heart beat, palpitations or pounding heart
 - Evidence of trembling or shaking You feel you are choking
 - Numbness or tingling sensations (paresthesia)
 - Lightheaded, dizzy, unsteady or faint You fear you are losing control or going crazy

100. CIRCLE BELOW - O - 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 / manic	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								