CASH/CHECK/CARD **DR. KRACKE & ASSOCIATES, P.A.** Therapist: ________

NEW CLIENT INFORMATION SHEET

*****APPOINTMENT DATE:*** ***APPT TIME:*** ***AM / PM***

PATIENT INFORMATION

WHO IS BEING SEEN: Full Name: ______________________ Date of Birth: ________

Age: ____ Sex: ______ Marital Status: ________ Social Security Number: ____________

Street Address: ______________________ City: __________ State: ____ Zip: ______

Mailing Address: ______________________ City: __________ State: ____ Zip: ______

Primary Phone Number: ____________ Please Circle: Cell / Work / Home OK to leave detailed message? Y N

Secondary Phone: ____________ Please Circle: Cell / Work / Home OK to leave detailed message? Y N

Employer – Name & Address: ______________________ Phone #: ________

If patient is a Student: School: ______________ Located: ____________ Grade: ____

All Current Medications & Dosages: ______________________

(if more space is needed, please ask for medication page)

Please list ALL Allergies: ______________________

Emergency Contact: ______________ Relationship: ________ Phone: ________

Emergency Contact: ______________ Relationship: ________ Phone: ________

Primary Care Physician: ______________ Date of last visit: ____________

Phone Number of Primary Care Physician: ____________ Fax number if known: ____________

Address of Primary Care Physician: ______________________

WHO IS THE RESPONSIBLE PARTY ***(Parent &/OR Primary Insurance Policy Holder)*****:** IF SAME PLEASE INDICATE

Full Name: ______________________ Relationship to Patient: —SAME

Soc. Sec. #: ____________ DOB: ________ E-Mail Address: ____________

Street Address: ______________________ City: __________ State: ____ Zip: ______

Mailing Address: ______________________ City: __________ State: ____ Zip: ______

Primary Phone Number: ____________ Please Circle: Cell / Work / Home OK to leave detailed message? Y N

Secondary Phone: ____________ Please Circle: Cell / Work / Home OK to leave detailed message? Y N

Employer's Name: ______________ Street Address: ______________

City: __________ State & Zip: ________ Employer's Phone #: ________ Extension: ______

Name Primary Insurance: ______________________

Subscriber ID #: ____________ Group #: ____________ Effective Date: ________

Address & Customer Service Phone #: ______________________

Does the Patient reside with you? ______, If not, where? ______________

ADDITIONAL RESPONSIBLE PARTY ***(Parent &/OR Secondary Insurance Policy Holder)*****:**

______________ Relationship to Patient: ______________

Soc. Sec. #: ____________ DOB: ________ E-Mail Address: ____________

Street Address: ______________________ City: __________ State: ____ Zip: ______

Mailing Address: ______________________ City: __________ State: ____ Zip: ______

Primary Phone Number: ____________ Please Circle: Cell / Work / Home OK to leave detailed message? Y N

Secondary Phone: ____________ Please Circle: Cell / Work / Home OK to leave detailed message? Y N

Employer's Name: ______________ Street Address: ______________

City: __________ State & Zip: ________ Employer's Phone #: ________ Extension: ______

Name Secondary Insurance: ______________________

Subscriber ID # ____________ Group #: ____________ Effective Date: ________

Address & Customer Service Phone #: ______________________

If Other Insurance, please list: ______________________

Please list ALL Insurance Companies from ANY & ALL SOURCES & please give cards AND Photo Identification to receptionist or your therapist for copying, Thank you!

***VERY IMPORTANT*:** *If you are seeing another mental health provider (psychiatrist, counselor, etc.) & you are on a managed care plan, or you have had an evaluation done elsewhere, it is essential that we have that information to know how many visits and how often to request authorization for further sessions:*

____

THE UNDERSIGNED HEREBY AUTHORIZES THE RELEASE OF ANY INFORMATION TO ALL OF MY INSURANCE COMPANY(IES) FOR CLAIMS SUBMITTED ON BEHALF OF MYSELF AND/OR MY DEPENDENTS. I FURTHER EXPRESSLY AGREE AND ACKNOWLEDGE THAT MY SIGNATURE BELOW AUTHORIZES DR. KRACKE & ASSOCIATES, P.A. TO SUBMIT CLAIMS FOR SERVICES RENDERED WITHOUT OBTAINING MY SIGNATURE ON ANY & ALL CLAIM(S) SUBMITTED. ANY FAILURE TO DISCLOSE ADDITIONAL INSURANCE WILL RESULT IN OUR BILLING YOU FOR THE CHARGES.

I UNDERSTAND I AM THE PARTY RESPONSIBLE FOR ALL CHARGES FOR SERVICES- REGARDLESS OF INSURANCE COVERAGE & AGREE TO ASSIGN ALL BENEFITS TO DR. KRACKE & ASSOCIATES, P.A. AND /OR PAY FOR SERVICE FOR ME AND/OR ANY OF MY DEPENDENTS OR PERSONS LISTED AS PATIENT, REGARDLESS OF RELATIONSHIP TO ME.

✕ ____

Signature for Primary Insurance *Date*

✕ ____

Signature for Secondary Insurance *Date*

Payment Amount per Visit $_______________ **Signed in Agreement** ________________________________

*Referred by:*__________________@______________ *Does Insurance Require Referral?*____ *Received?*_____

***May we send a THANK YOU note to Referring Physician as a Professional Courtesy?* ___*YES* ___*NO*

*Permission given or denied by:*______________________________ *Relationship to Client:*________________

Signature of Client over 18 or Responsible Party

Intake Information Form-Adult

Name:_____________________ Date of Birth:__________ Age:____ Today's Date__________

In order to assist the intake worker obtaining a thorough understanding of your current situation, please complete this intake packet by either filling in, circling items as appropriate.

Identifying information

I currently live in ____________________, Idaho for approximately _______ (months - years).
I am currently (employed - unemployed). If employed, I currently work at__________________
I have worked at this company for ____________ (months - years).
I am currently (single – married - separated - divorced.) The quality of my marital relationship is (good – fair - poor). The quality of my family relationship is (good – fair - poor).
I have been married (1 – 2 - 3) times.
I have (no – 1 – 2 – 3 - 4 or more) children.

Presenting problem

My current mental health concern is my _____________________. The severity of this current mental health concern is (mild – moderate – severe - disabling). Please list two observable symptoms of your current mental health concern, (for example, crying, poor appetite, intrusive thoughts)
__________________________________ and _____________________________.

History of presenting problem

My current concern has been in evidence for (weeks – months - years). I (have - have not) addressed these mental health concerns with other mental health professionals. If yes-please list previous mental health professionals____
Previous treatment was obtained in the (last year - a number of years ago - cannot remember).

Adequacy of Previous Treatment

My previous treatment, in my estimation proved to be (only marginally – minimally) effective.

Educational history

I (graduated - did not graduate from high school – College - earned a GED) in ________ (year).
My overall success academically was (below average – average - above average). I completed ______ years of education all together, including ______ years of college.

Employment history

Prior to my current employment, my previous employment was at ____________________ for _______(months - years).

Family history

I (do not - do) have a family history of mental health related issues. In my family, there appears to be a history of (depression – anxiety - alcohol abuse - other psychiatric disorders) in the following family members (mother – father – siblings - maternal grandparents - paternal grandparents).

Abuse history
In the past I (have been - have not been) abused (physically – sexually – emotionally - neglected) by my (parents - other family members – partner - unknown stranger). This occurred during my (childhood – adolescence - adulthood).

Substance use
I currently smoke (yes - no)
I currently use alcohol (not at all – minimally – moderately - excessively).
I currently use prescription drugs (not at all – minimally – moderately - excessively).
Currently I am using (alcohol - prescription medications – marijuana – uppers – downers – crank – crack - IV substances) on a (daily – weekly - monthly) basis.

Medical history
I have significant medical difficulties with my (heart – stomach – cancer – pain - high blood pressure – diabetes - weight related issues – kidneys – lungs - allergies &/or _______________). There has been a recent change in my (weight – appetite - sleep pattern).

Medication history
I am currently taking the following medications __________________ for my medical condition.

For mental health issues, I am taking _____________________ (medication) for _____(months) _____ (years) and the current dosage is _________. This medication has had (positive benefits - negative effects) as indicated by ____.

For mental health issues, I am taking _____________________ (medication) for _____(months) _____ (years) and the current dosage is _________. This medication has had (positive benefits - negative effects) as indicated by ____.

For mental health issues, I am taking _____________________ (medication) for _____(months) _____ (years) and the current dosage is _________. This medication has had (positive benefits - negative effects) as indicated by ____.

Psychiatric history (circle all those that apply)
I have a history of (depression – anxiety - hearing things that others say aren't there - lots of thoughts coming at the same time - quick mood changes – changes in appetite - sleep related difficulties - energy related difficulties - wishing I was dead - psychiatric hospitalizations - flashbacks of bad things that had happened to me - repetitive thoughts - compulsive behavior - phobias - unusual perceptual experiences - disturbances of consciousness – seizures – blackouts – amnesia - repetitive behaviors to do something or to check something - sexual dysfunction - anger related issues - violent behavior - &/or _____________ ____________________________________).
Generally I am (outgoing - stay to myself - just like everyone else) when it comes to being sociable.

Baseline Measure
Using the following scale with 10 being high and zero being nothing ranked your level of the following: depression = _____, anxiety = _____, and irritability/anger = _____ , pain = _____.

Thank you for taking the time to complete this medical background information.

In an effort to provide quality care we regularly ask our patients to complete the following Inventory. This instrument is widely used in university counseling centers and other mental health settings to evaluate client progress in therapy over time. You may be asked to complete this regularly during your treatment and will be tracked during the course of therapy with us. Thank you

Your Name:___________________________________ Today's Date:______________

Using the scale from 0 to 4 rate each of the following looking back on the past week including today.

0	1	2	3	4
Never	Seldom	Occasionally	Frequently	Almost Always

Your Rating on this Item

1. I get along with others. ____
2. I tire quickly. ____
3. I feel no interest in things. ____
4. I feel stressed at work/school. ____
5. I blame myself for things. ____
6. I feel irritated. ____
7. I feel unhappy in my marriage/significant relationship. ____
8. I have thoughts of ending my life. ____
9. I feel weak. ____
10. I feel fearful. ____
11. After heavy drinking, I need a drink the next morning to get going. (If you do not drink mark "never"). ____
12. I find my work/school satisfying. ____
13. I am a happy person. ____
14. I work/study too much. ____
15. I feel worthless. ____
16. I am concerned about family troubles. ____
17. I have an unfulfilling sex life. ____
18. I feel lonely. ____
19. I have frequent arguments. ____
20. I feel loved and wanted. ____
21. I enjoy my spare time. ____
22. I have difficulty concentrating. ____
23. I feel hopeless about the future. ____
24. I like myself. ____
25. Disturbing thoughts come into my mind that I can't get rid of. ____
26. I feel annoyed by people who criticize my drinking (or drug use). (If not applicable mark "never"). ____

27. I have an upset stomach. ____
28. I am working/studying less well than I used to. ____
29. My heart pounds too much. ____
30. I have trouble getting along with friends and close acquaintances. ____
31. I am satisfied with my life. ____
32. I have trouble at work/school because of drinking or drug use.
    (If not applicable mark "never"). ____
33. I feel that something bad is going to happen. ____
34. I have sore muscles. ____
35. I feel afraid of open spaces, or of driving, or being on buses, etc. ____
36. I feel nervous. ____
37. I feel my love relationships are full and complete. ____
38. I feel that I am not doing well at work/school. ____
39. I have too many disagreements at work/school. ____
40. I feel something is wrong with my mind. ____
41. I have trouble falling asleep or staying asleep. ____
42. I feel blue. ____
43. I am satisfied with my relationships with others. ____
44. I feel angry enough at work/school to do something I might regret. ____
45. I have headaches. ____

_ _ _ _ _ _ _ _ _
For Office Use

Reverse Score items 1, 12, 13, 20, 21, 24, 31, 37, 43,

Total OQ-45 Score is _____ (cutoff score is 67)

Symptom Distress (SD), items 2, 3, 5, 6, 8, 9, 10, 13, 15, 22, 23, 24, 25, 29, 31, 33, 34, 35, 36, 41, 42, 45 _____ (cutoff score is 35)

Social-Role functioning (SR) items 4, 12, 14, 21, 28, 32, 38, 39, and 44 _____ (cutoff score is 12)

Interpersonal Relationships (IR) items1, 7, 16, 17, 18, 19, 20, 26, 30, 37, 43 _____ (cutoff score is 15)

The SD subscale taps into general emotional and lifestyle stressors such as depression, anxiety, stress, substance abuse, and suicidality The SR subscale measures clients' work
relations and leisure activities, with scores ranging from 0 to 36. The IR subscale assesses clients' satisfaction with interpersonal relationships, especially marital and family relationships and friendships

CLINIC INTERVIEW FOR ADULTS

Name:______________________________Today's Date:_____________Birth Date:______________Reason f or seeking evaluation now:____

____

Referral by: ____

Reason for Referral: ____

____

Objectives: ____

____

____

____

____

What is your main or most distressing psychological concerns ? __________________

____

____

____

What are your greatest concerns about your current behavior? ______________________________

____

____

____

Do you know anyone who has been diagnosed with Mental Disorder? __________
If yes, were they treated with (please circle one) – medication – therapy – unknown?

1. How old were you when the problem behavior began?

0-7 yrs ____
8-12 yrs ____
13-15 yrs ____
16-21 yrs ____
22 + yrs _____

2. Were the following symptoms more of a problem for you than for others in your peer group?

Symptom	As a Child		Is it now – Same/Better/Worse	Comments
	Yes	No		
Fidgety /restless				
Difficulty remaining satisfied				
Easily distracted				
Difficulty awaiting your turn				
Blurt answers out before question is com pleted				
Difficulty following instructions or completing tasks				
Difficulty sustaining attention in tasks				
Frequently shift from one task to another				
Talk too much				
Difficulty doing tasks alone				
Often interrupt others				
Often don't listen				
Often lose things or forget things				
Engage in dangerous/ physically daring activities				
Always on the go, as if driven by a motor				
Make decisions or act too quickly				
Impatient				

3. Did you ever seek treatment for these problems before? Yes/No

If yes, when and where did you seek treatment? ____

What was the recommended treatment and outcome of that treatment? ____________________

____

I. DEVELOPMENTAL HISTORY

4. As far as you know, were there any problems with your mother's pregnancy or delivery of you? Yes/No
If yes, give details: ____

____

5. As far as you know, did you walk/talk/sit up on time? Yes/No

If no, give details: ____

____

6. Did you have any childhood illnesses? Yes/No

If yes, give details: ____

7. Did you have normal relationships with your peers when you were a child? Yes/No

If no, explain: ____

____

8. Did your parents complain that you were difficult to control as child? Yes/No/ Not sure

If yes, during what ages did they have this complaint? (Circle all that apply):

0-7yrs 8-12yrs 13-15 yrs 16-21 yrs 22+ yrs

9. Did your parents ever take you to see anyone about these problems when you were a child or adolescent ? Yes/No/ Not sure

10. What was the highest level of school you completed?

___ <6th Grade ___ 7th /8th Grades ___ High School Freshman/Sophomore

___ High School Junior ___ High School Grad/GED ___ 1-2 yrs College

___ 3-4 yrs College ___ Masters/ Post-grad ___ Doctorate

11. Did you have any trouble starting school in kindergarten or first grade? ___________________

____

12. Did you ever repeat a grade? Yes/No

If yes, what grade(s)? ____

13. Were you ever in any special classes in school? Yes/No

If yes, what kind? ____

14. How would you describe your grades in school? Average/Better than average/ Worse than

15. What was your best subject in school? _____________________ Your worst? ________________

16. Did your teachers think you did as well as you could? Yes/No/Not sure

17. Were you ever truant from school? Yes/No

If yes, how often and during what grades? ____

18. Were you ever expelled or suspended from school? Yes/No

19. Did you ever get in any physical fights at school? Yes/No

If yes, during what grades? _______________

How many times? Once/ 2-5 times/ 6-10 times/ 11+ times

Did you start the fight? Yes/No/Not sure

Did you ever us a weapon in a fight? Yes/No

20. Did you ever run away from home overnight? Yes/No

If yes, how many times? Once/ 2-5 times/ 6-10 times/ 11+ times

What was the longest you stayed away? A night/ 2-5 nights/ 6-10 nights/ 11+ nights

21. Did you ever get in trouble for stealing or damaging property as a child or teenager? Yes/No

II. PERSONAL HISTORY

22. Have you ever been arrested or in trouble with the law? Yes/No

23. Do you have a driver's license? Yes/No

If yes, how many traffic tickets (not parking tickets) have you ever received?

___None ___One ___2-3 ___4+

How many car accidents have you ever been in?

___0 ___1 ___2 ___3 ___4+

If no, why don't you have a driver's license? ____

____

24. Do you have problems with your temper? Yes/No

If yes, please give details: ____

____

25. Did you have problems with your temper as a child or teenager? Yes/No/Not sure

26. Have you ever lost your temper enough to hurt anyone or damage any property?

Yes/No/Not sure

27. Do other people complain about your temper? Yes/No/Not sure

28. How would you describe your mood most of the time?

a. normal and fairly stable
b. anxious or nervous
c. depressed, sad or blue
d. labile – my mood changes a lot, goes up and down
e. other ____

29. Do you have any problems with you sleep? Yes/No

If yes, please give details: ____

30. Do you ever use any diet preparations? Yes/No

If yes, which ones? ____

31. How much alcohol do you drink in a *week*?

___Never ___0-1 ___2-4 ___5-10 ___10+

Please explain: ____

____

32. Do you ever drink more heavily at one time versus another? Yes/No

If yes, explain: ____

____

33. Have you ever used any drugs recreationally? Yes/No

If yes, which ones? (circle all that apply) Frequency

Pot, marijuana, hashish, grass	
Amphetamines, stimulants, uppers, speed	
Barbiturates, sedatives, downers, sleeping pills, S econal, Quaaludes	
Tranquilizers – Valium, Librium, etc.	
Cocaine, coke, crack	
Heroin	
Opiates other than heroin - iodine, Demerol, mo rphine, methadone, Darvon, opium	
Other (specify) -	

34. Do you use any drugs recreationally now? Yes/No

If yes, what and how often? ____

35. Have you ever misused prescription drugs? Yes/No

If yes, what and when? ____

II. PSYCHIATRIC HISTORY

36. Have you ever seen a counselor or psychiatrist? Yes/No

If yes, when, where and why? ____

____

37. Have you ever been hospitalized for a psychological or psychiatric problem? Yes/No

If yes, when, where and why? ____

____

38. Have you ever had problems with depression? Yes/No

If yes, give details: ____

____

39. Have you ever had any problems with anxiety? Yes/No

If yes, give details: ____

____

MEDICAL HISTORY

40. Please list any current medical problems: ____

____

____

41. If you've ever been hospitalized, when and why? ____

____

____

42. Have you ever had heart problems? Yes/No

If yes, give details: ____

43. Have you ever had liver disease? Yes/No

If yes, give details: ____

44. Have you ever had glaucoma? Yes/No

If yes, give details: ____

45. Have you ever suffered from seizures? Yes/No

If yes, give details: ____

46. Do you have high blood pressure? Yes/No

If yes, give details: ____

47. Do you ever suffer from chest pain or shortness of breath? Yes/No

If yes, give details: ____

48. Have you ever injured your head or had a concussion? Yes/No

If yes, give details: ____

49. Have you ever lost consciousness? Yes/No

If yes, give details: ____

50. Have you ever had encephalitis or a brain infection? Yes/No

If yes, give details: ____

51. Have you ever had any tics or unusual movements of your body? Yes/No

If yes, give details: ____

52. Have you ever had any vocal tics or do you make any unusual noises (Tourette's)? Yes/No

If yes, give details: ____

53. **Have you ever had any problems with your thyroid gland? Yes/No**

If yes, give details: ____

54. **Are right/left sided for each of the following? (mark each as R, L or Amb)**

a. Writing ______ **c. Throwing ______**

b. Kicking ______ **d. Seeing/Sighting ______**

SEXUAL HISTORY

55. **Are you sexually active? Yes/No**

[FOR WOMEN]

56. **Are you trying to become pregnant? Yes/No**

57. **Do you intend to become pregnant within the next five years? Yes/No**

58. **Are you using birth control? Yes/No**

59. **Are currently nursing a child? Yes/No**

MEDICATIONS

60. **Please list any medications you are currently taking or provide list: ____________________**

____

____

61. **List any over-the-counter medications or supplements: ______________________________**

____

____

ALLERGIES

62. **List any medications allergies: ____**

____

63. **List all other allergies: ____**

FAMIILY HISTORY

64. **List any family history of medical illness: ____**

____

65. **Is there a family history of anxiety or depression? Yes/No**
    If yes, give details: ____

____

66. **Is there a family history of alcohol/drug abuse? Yes/No**
    If yes, give details: ____

____

67. **Is there a family history of psychiatric illness? Yes/No**
    If yes, give details: ____

____

____

68. **Has anyone in your family been in trouble with the law? Yes/No**
    If yes, explain: ____

____

69. **Is there a family history of Tourette's syndrome or vocal tics? Yes/No**
    If yes, give details: ____

70. **Is there anyone in your family who has suffered from movement disorders or unusual movements? Yes/No**
    If yes, give details: ____

71. **Is there a family history of heart disease? Yes/No**
    If yes, give details: ____

72. **Is there a family history of high blood pressure? Yes/No**
    If yes, give details: ____

73. Is there a family history of attention problems? Yes/No

If yes, give details: ____

____

74. Is there a family history of learning disabilities? Yes/No

If yes, give details: ____

____

75. Do you struggle in your relationships with others? Yes/No

If yes, explain: ____

____

____

76. How many intimate relationships have you had that lasted more than 3 months?

a. none	**c. 3-4**
b. 1-2	**d. 5+**

77. Are there any other problems or difficulties you have that might be related to your purpose in seeking evaluation?

____

____

____

____

____

____

____

____

____

____

____

Please rate the degree to which you have been experiencing the following problems during THIS PAST WEEK by making an "X" over the appropriate number. Circle the 3 proble ms you consider to be causing the most difficulty.

	Not a Problem									Very Severe Problem

1. Anxiety |---|---|---|---|---|---|---|---|---|---|
0 1 2 3 4 5 6 7 8 9 10

2. Depression |---|---|---|---|---|---|---|---|---|---|
0 1 2 3 4 5 6 7 8 9 10

3. Disturbing thoughts |---|---|---|---|---|---|---|---|---|---|
0 1 2 3 4 5 6 7 8 9 10

4. Fears/Fearfulness |---|---|---|---|---|---|---|---|---|---|
0 1 2 3 4 5 6 7 8 9 10

5. Temper/Angry Outbursts |---|---|---|---|---|---|---|---|---|---|
0 1 2 3 4 5 6 7 8 9 10

6. Eating Problems |---|---|---|---|---|---|---|---|---|---|
0 1 2 3 4 5 6 7 8 9 10

Specify: ____

7. Sleep Problems |---|---|---|---|---|---|---|---|---|---|
0 1 2 3 4 5 6 7 8 9 10

8. Fatigue |---|---|---|---|---|---|---|---|---|---|
0 1 2 3 4 5 6 7 8 9 10

9. Sexual Problems |---|---|---|---|---|---|---|---|---|---|
0 1 2 3 4 5 6 7 8 9 10

Specify: ____

10. Alcohol/Drug Problems |---|---|---|---|---|---|---|---|---|---|
0 1 2 3 4 5 6 7 8 9 10

Specify: ____

11. Stress |---|---|---|---|---|---|---|---|---|---|
0 1 2 3 4 5 6 7 8 9 10

Specify: ____

12. Work/School Problems |---|---|---|---|---|---|---|---|---|---|
0 1 2 3 4 5 6 7 8 9 10

13. Family/Relationship Problems |---|---|---|---|---|---|---|---|---|---| 0 1 2 3 4 5 6 7 8 9 10

Specify: ____

14. Child-rearing Problems |---|---|---|---|---|---|---|---|---|---| 0 1 2 3 4 5 6 7 8 9 10

15. Problems getting along with others |---|---|---|---|---|---|---|---|---|---| 0 1 2 3 4 5 6 7 8 9 10

16. Violence |---|---|---|---|---|---|---|---|---|---| 0 1 2 3 4 5 6 7 8 9 10

Specify: ____

17. Health Problems |---|---|---|---|---|---|---|---|---|---| 0 1 2 3 4 5 6 7 8 9 10

Specify: ____

18. Legal Problems |---|---|---|---|---|---|---|---|---|---| 0 1 2 3 4 5 6 7 8 9 10

Specify: ____

19. Financial Problems |---|---|---|---|---|---|---|---|---|---| 0 1 2 3 4 5 6 7 8 9 10

20. Other: |---|---|---|---|---|---|---|---|---|---| 0 1 2 3 4 5 6 7 8 9 10

Specify: ____

21. Other: |---|---|---|---|---|---|---|---|---|---| 0 1 2 3 4 5 6 7 8 9 10

Specify: ____

22. Other: |---|---|---|---|---|---|---|---|---|---| 0 1 2 3 4 5 6 7 8 9 10

Specify: ____

PHYSICAL COMPLAINT CHECKLIST

Below is a list of symptoms that some people experience. Indicate how often you are bothered by each item by checking the a ppropriate box.

	Never	A few times a year	Once a m onth	Once a week	Several times a week	Daily
Headaches						
Trouble sleeping						
Irritable/ Nervous						
Stomach upset						
Aches & pains						
Backache						
Rapid heart beat						
Dizzy/ lightheaded						
Nausea/ vomiting						
Diarrhea						
Constipation						
Weakness						
Tired during day						
Poor appetite						
Blurred vision						
Dry mouth						
Confusion						

Symptom Checklist

Below is a list of some problems and behaviors that people may have. Beside each item indicate how much of a problem eac h one is for you in your opinion.

	Never	Just a little	Somewhat often	Very often
Physical restlessness				
Mental restlessness				
Easily distracted				
Impatient				
"Hot" or explosive temper				
Unpredictable behavior				
Difficulty completing tasks				
Shifting from one task to another				
Difficulty concentrating				
Impulsivity				
Talking too much				
Difficulty doing tasks alone				
Interrupting others				
Not appearing to listen				
Loosing things				
Forgetting things				
Engaging in physically daring activities				
Always on the go, as if driven by a motor				

THIS SHEET IS ABOUT THE PATIENT'S FATHER (paternal relatives):

0=No; 1=Yes

	Father	Father's Father	Father's Mother	Father's Siblings: Bro	Father's Siblings: Bro	Father's Siblings: Sis	Father's Siblings: Sis	Total
Problems with aggressive, defiance, & oppositional behavior as a child.								
Problems with attention, activity, & impulse control as a child.								
Learning disabilities.								
Failed to graduate from high school.								
Mental retardation.								
Psychosis or schizophrenia								
Depression for more than 2 weeks.								
Anxiety disorder that impaired adjustment.								
Tics or Tourette's								
Alcohol abuse								
Substance abuse								
Antisocial behavior (assaults, thefts, etc.)								
Arrests								
Physical abuse								
Sexual abuse								
Periods of Euphoria, excitability, decrease need for sleep or mania								

THIS SHEET IS ABOUT THE PATIENT'S MOTHER (maternal relatives):

0=No; 1=Yes

	Mother	Mother's Father	Mother's Mother	Mother's Siblings				
				Bro	Bro	Sis	Sis	Total
Problems with aggressive, defiance, & oppositional behavior as a child.								
Problems with attention, activity, & impulse control as a child.								
Learning disabilities.								
Failed to graduate from high school.								
Mental retardation.								
Psychosis or schizophrenia								
Depression for more than 2 weeks.								
Anxiety disorder that impaired adjustment.								
Tics or Tourette's								
Alcohol abuse								
Substance abuse								
Antisocial behavior (assaults, thefts, etc.)								
Arrests								
Physical abuse								
Sexual abuse								
Periods of Euphoria, excitability, decrease need for sleep or mania								

THIS SHEET IS ABOUT THE PATIENT'S SIBLINGS:

0=No; 1=Yes

	Patient's Brother	Patient's Brother	Patient's Sister	Patient's Sister	Total
Problems with aggressiveness, defiance, & oppositional behavior as a child.					
Problems with attention, activity, & impulse control as a child.					
Learning disabilities.					
Failed to graduate from high school.					
Mental retardation.					
Psychosis or schizophrenia					
Depression for more than 2 weeks.					
Anxiety disorder that impaired adjustment.					
Tics or Tourette's					
Alcohol abuse					
Substance abuse					
Antisocial behavior (assaults, thefts, etc.)					
Arrests					
Physical abuse					
Sexual abuse					
Periods of Euphoria, excitability, decrease need for sleep or mania					

WENDER UTAH RATING SCALE

AS A CHILD I WAS (OR HAD)	NOT AT ALL OR VERY SLIGHTLY	MILDLY	MODER-ATELY	QUITE A BIT	VERY MUCH
Active, restless, always on the go					
Afraid of things					
Concentration problems, easily distracted					
Anxious, worried					
Nervous, fidgety					
Inattentive, daydreaming					
Hot- or short-tempered, low boiling point					
Trouble with sticking to a project, not following through, or not finishing things started.					
Temper outbursts, tantrums					
Strong-willed					
Sad or blue, depressed, unhappy					
Incautious, daredevil, involved in pranks					
Not getting a kick out of things, dissatisfied with life					
Disobedient with parents, rebellious, sassy					
Low opinion of myself					
Irritable					
Outgoing, friendly, enjoyed company of people					
Sloppy, disorganized					
Moody with ups and downs					
Angry					
Friends, popular					
Well-organized, tidy, neat					
Acting without thinking, impulsive					
Tendency to be immature					
Guilty feelings, regretful					
Losing control of myself					
Tendency to be or act irrational					
Unpopular with other children, didn't keep friends for long or didn't get along with other children					
Poorly coordinated, did not participate in sports					
Afraid of losing control of self					
Well-coordinated, picked first in games					

PLEASE CONTINUE TO PAGE 2 ON REVERSE

AS A CHILD I WAS (OR HAD)	NOT AT ALL OR VERY SLIGHTLY	MILDLY	MODER -ATELY	QUITE A BIT	VERY MUCH
Tomboy (for females only)					
Running away from home					
Getting into fights					
Teasing other children					
Leader, bossy					
Difficulty getting awake					
Follower, led around too much					
Trouble seeing things from someone else's point of view					
Trouble with authorities, trouble in school, visits to the principal's office					
Trouble with police, booked, convicted					
MEDICAL PROBLEMS AS A CHILD					
Headaches					
Stomach aches					
Constipation					
Diarrhea					
Food Allergies					
Other allergies					
Bedwetting					
AS A CHILD IN SCHOOL, I WAS (OR HAD)					
Overall a good student, fast learner					
Overal a poor student, slow learner					
Slow in learning to read					
Slow reader					
Trouble reversing letters					
Problems with spelling					
Trouble with math or numbers					
Bad handwriting					
Able to read pretty well, but never really enjoyed reading					
Not achieving up to potential					