ADULT INTAKE QUESTIONNAIRE

Patient Information:

Name: Gender: Male Female Transgender

Date of Birth: Age: Spouse's Name:

Marital Status: Single Married Separated Divorced Widowed

Race: Religion: Number of Children:

Home Address:

Cell Phone Number: Home Phone Number:

Email:

Responsible Party:

Name of Responsible Party:

Cell Phone Number: Home Phone Number:

Referral Source:

How did you hear about Amen Clinic?

Name: Specialty/Credentials:

Phone Number: Address:

Chief Complaint:

What is the main purpose of your consultation/What are your goals for your evaluation?

How severe are your symptoms? (circle one)

Normal, not at all symptomatic
Borderline symptomatic
Mildly symptomatic
Moderately symptomatic
Markedly symptomatic
Severely symptomatic
Among the most extremely symptomatic patients

Prior Attempts to Correct Problems:

Please indicate whether you have been under the care of any of the following:

Psychiatrist (Dates): Reason for Treatment:
Therapist (Dates): Reason for Treatment:
Neurologist (Dates): Reason for Treatment:
Naturopath (Dates): Reason for Treatment:
Other(Dates):
Reason for Treatment:

Indicate if you have any history of the following:

Inpatient Psychiatric Hospitalization (Dates):
Reason for Treatment:
Outpatient Treatment Program (Dates):
Reason for Treatment:

Please list any diagnoses you have received (including medical ailments, psychiatric conditions, and learning disabilities):

Medication History:

Dates Taken:	Medication:	Dosage:	Effectiveness:	Side Effects:

Current Supplements:

Dates Taken:	Medication:	Dosage:	Effectiveness:	Side Effects:

Medical History:

Present Height: Present Weight: Present Waist Size:

Date of last menstrual period if menstruating:

Do you have any history of seizure activity? (Explain):

Do you have any history of exposure to environmental toxins (mold, fumes, etc.)? (Explain):

Head Injury/Brain Traumas

Please indicate if you have any history of the following:

- Falls
- Motor Cycle Accidents
- Loss of consciousness
- Sports related concussions
- Assaults
- Altered consciousness (such as seeing stars, forgetfulness, etc.)

Describe anything checked above including the approximate date it occurred:

Do you have any history of abnormal test or lab results? (Explain):

Medical Review

Please place a check mark in the box/boxes that apply (C = Current, P = Past).

General

C P

- Being overweight
- Weight loss
- Sensitive to hot or cold
- Cold or hot spells
- Fatigue
- Lowered resistance to infection
- Flu-like or vague sick feeling
- Night sweats
- Daytime sweating
- Excessive thirst
- Other:

Neurological

C P

- Seizures
- Dizziness
- Vertigo
- Muscle spasms or tremors
- Slurred speech
- Speech problems
- Muscle weakness
- Other:

Respiratory

C P

- Asthma, wheezing
- Cough
- Coughing up blood or sputum
- Shortness of breath
- Rapid breathing
- Repeated nose or chest colds
- Other:

Chest and Cardiovascular

C P

- Ankle swelling Rapid/irregular pulse
- High cholesterol
- Low cholesterol Breast tenderness
- Chest pain
- High blood pressure Low blood pressure Stroke
- Other:

Head, Eye, Ear, Nose, & Throat

C P

- Facial pain
- Headache
- Neck pain or stiffness
- Frequent sore throat
- Blurred or double vision

C P

- See spots or shadows
- Hearing loss
- Ear ringing
- Chronic ear infections
- Disturbances in smell
- Dry mouth
- Sore tongue
- Other:

Gastrointestinal and Hepatic

C P

- Nausea or vomiting
- Abdominal (stomach/belly) pain
- Anal itching
- Painful bowel movements
- Infrequent bowel movements
- Liquid bowel movements
- Loss of bowel control
- Frequent belching or gas
- Vomiting blood
- Rectal bleeding (red or black blood)
- Jaundice (yellowing of skin)
- Other:

Musculoskeletal

C P

- Arthritis
- Back pain or stiffness
- Bone pain
- Joint pain or stiffness
- Leg pain
- Muscle cramps or pain
- Other:

Skin and Hair

C P

- Dry hair or skin
- Itchy skin or scalp
- Easy bruising
- Hair loss
- Increased perspiration
- Sun sensitivity
- Other:

Genitourinary

C P

- Itchy privates or genitals
- Painful urination
- Excessive urination
- Decreased sexual desire
- Other

Females

C P

- No menses
- Menstrual irregularity
- Painful or heavy periods Premenstrual moodiness,
- irritability, anger, tension, bloating, breast tenderness, cramps, and headache
- Painful intercourse or sex
- Sterility/infertility
- Abnormal vaginal discharge
- Other:

Males

C P

- Impotence (weak male erection)
- Inability to ejaculate or orgasm
- Scrotal pain
- Abnormal penis discharge
- Other:

Surgical Procedures

C P

- Tonsillectomy
- Adenoidectomy
- Myringotomy (ear tubes)
- Appendectomy
- Hernia repair
- Other:

Illnesses

C P

- Pneumonia
- Hypothyroidism
- Hyperthyroidism
- Chronic Fatigue Syndrome
- Fibromyalgia
- Encephalitis
- Meningitis
- Lyme Disease
- Lupus
- Epstein - Barr virus
- Fevers over 105°
- Autoimmune Disorder
- Other:

Previous Medical Hospitalizations

Date:	Length of stay:	Reason for hospitalization:

Medication Allergies or Intolerances:

Diet/Exercise History

Is your diet mostly healthy or unhealthy?

Are you currently on a restricted diet? Explain:

Do you have any food allergies or sensitivities?

Describe your current exercise regimen:

Addiction History

Have you or others been concerned about the role alcohol or drugs have come to play in your life? (Explain):

Do you have any behavioral addictions such as spending, gambling, sexual compulsivity, overeating, internet/gaming addiction, etc.? (Explain):

Please indicate if you have used or experimented with any of the following substances. Include information about the dates used, extent of use, and effects of use (benefits, side effects, changes in mood, etc.):
(C=Current P=Past)

C P

Alcohol (hard liquor, beer, wine):

Nicotine (cigarettes, cigars, chewing tobacco):

Marijuana/Hash:

Inhalants (glue, gasoline, cleaning fluids, etc.):

Cocaine/Crack:

Amphetamines:

Steroids:

Opiates (heroin, Oxycodone, morphine, other pain killers):

Barbiturates:

Hallucinogens (LSD, mescaline, mushrooms, ecstasy):

Prescription tranquilizers/Sleeping pills:

Other:

Sleep Behavior

Do you have any problems falling asleep? Yes No

Do you have any problems staying asleep? Yes No

Do you have any problems waking up? Yes No

On average, how many hours do you sleep per night?

Please indicate if you have any history of the following:

Sleepwalking? Yes No Recurrent dreams? Yes No

Sleep apnea? Yes No Heavy snoring? Yes No

Sleep Bruxism (grinding you teeth)? Yes No

Family History

Biological Mother's History: Living Deceased; Age Cause of death

Medical problems:

Learning or psychiatric problems:

Alcohol/Drug abuse history:

Have any of your mother's blood relatives ever had any learning, psychiatric, or substance abuse problems?

Biological Father's History: Living Deceased; Age Cause of death

Medical problems:

Learning or psychiatric problems:

Alcohol/Drug abuse history:

Have any of your mother's blood relatives ever had any learning, psychiatric, or substance abuse problems?

Patient's Siblings: (Include names and ages. Indicate if your sibling has ever had any learning, psychiatric, or substance abuse problems.)

Patient's Children: (Include names and ages. Indicate if your child has ever had any learning, psychiatric, or substance abuse problems.)

PSYCHOLOGICAL INFORMATION

Significant Life Events: (Include marriages, separations, divorces, death, traumatic events, losses, successes, failures, etc.)

Do you have any history of suffering physical, sexual, or emotional trauma?

SOCIAL INFORMATION

Current Life Stressors: (Include anything that is currently stressful for you. Examples include relationships, job, school, finances, children, etc.)

School History: Highest level of education completed

Average grades received

Learning strengths

Learning disabilities

Behavioral problems

Employment Information: Current Occupation

Past jobs

Work-related problems

Do you have any military history? (Explain)

Do you have any history of legal problems? (Explain):

Family Structure: (Who lives in your current household? Describe how you get along with each.)

Please describe your current marital or relationship satisfaction:

Do you have any history of previous marriages? (How many?)

Sexuality: Do you have any current sexual problems

SPIRITUAL INFORMATION

What is your spiritual background?

Have you had any unusual spiritual experiences including out of body or near death experiences?

What spiritual practices have you tried (i.e. mediation, prayer etc.)?

AMEN ADULT GENERAL SYMPTOM CHECKLIST | Copyright Daniel G. Amen, MD

Please rate yourself on each of the symptoms listed below using the following scale. If possible, to give us the most complete picture, have another person who knows you well (such as a spouse, partner or parent) rate you as well. List the person's relationship to you:

0| Never 1| Rarely 2| Occasionally 3| Frequently 4| Very Frequently NA| Not Applicable

Other Self

1. Feeling depressed or being in a sad mood
2. Having a decreased interest in things that are usually fun, including sex
3. Experiencing a significant change in weight or appetite, increased or decreased
4. Having recurrent thoughts of death or suicide
5. Experiencing sleep changes, such as a lack of sleep or a marked increase in sleep
6. Feeling physically agitated or of being "slowed down"
7. Having feelings of low energy or tiredness
8. Having feelings of worthlessness, helplessness, hopelessness or guilt
9. Experiencing decreased concentration or memory
10. Having periods of an elevated, high or irritable mood
11. Having periods of a very high self-esteem or grandiose thinking
12. Having periods of decreased need for sleep without feeling tired
13. Being more talkative than usual or feeling pressure to keep talking
14. Having racing thoughts or frequently jumping from one subject to another
15. Being easily distracted by irrelevant things
16. Having a marked increase in activity level
17. Excessive involvement in pleasurable activities that have the potential for painful consequences (e.g., spending money, sexual indiscretions, gambling, foolish business ventures)
18. Experiencing panic attacks, which are periods of intense, unexpected fear or emotional discomfort (list number per month)
19. Having periods of trouble breathing or feeling smothered
20. Having periods of feeling dizzy, faint or unsteady on your feet
21. Having periods of heart pounding or rapid heart rate
22. Having periods of trembling or shaking
23. Having periods of sweating

Other Self

24. Having periods of choking
25. Having periods of nausea or abdominal discomfort/trouble
26. Having feelings of a situation “not being real”
27. Experiencing numbness or tingling sensations
28. Experiencing hot or cold flashes
29. Having periods of chest pain or discomfort
30. Fearing death
31. Fearing going crazy or doing something out-of-control
32. Avoiding everyday places for 1) fear of having a panic attack or 2) needing to go with other people in order to feel comfortable
33. Excessive fear of being judged by others, which causes you to avoid or get anxious in situations
34. Experiencing persistent, excessive phobia (heights, closed spaces, specific animals, etc.), please list:

35. Having recurrent bothersome thoughts, ideas, or images that you try to ignore
36. Having trouble getting “stuck” on certain thoughts, or having the same thought over and over
37. Experiencing excessive or senseless worrying
38. Others complaining that you worry too much or get “stuck” on the same thoughts
39. Having compulsive behaviors that you must do or else you feel very anxious, such as excessive hand washing, checking locks, or counting or spelling
40. Needing to have things done a certain way or else you become very upset
41. Others complaining that you do the same thing over and over to an excessive degree (such as cleaning or checking)
42. Experiencing recurrent and upsetting thoughts of a past traumatic event (molestation, accident, fire, etc.), please list:

43. Experiencing recurrent distressing dreams of a past upsetting event
44. Having a sense of reliving a past upsetting event
45. Having a sense of panic or fear of events that resemble an upsetting past event
46. Spending effort avoiding thoughts or feelings associated with a past trauma
47. Regularly avoiding activities/situations which cause remembrance of an upsetting event
48. Being unable to recall an important aspect of a past upsetting event
49. Having a marked decreased interest in important activities

Other Self

50. Feeling detached or distant from others
51. Feeling numb or restricted in your feelings
52. Feeling that your future is shortened
53. Being quick to startle
54. Feeling like you're always watching for bad things to happen
55. Experiencing a marked physical response to events that remind you of a past upsetting event (e.g., sweating, increased pulse, etc.) when getting in a car if you had been in a car accident
56. Being markedly more irritable or experiencing anger outbursts
57. Having unrealistic or excessive worry in at least a couple areas of your life
58. Trembling, twitching, or feeling shaky
59. Experiencing muscle tension, aches, or soreness
60. Having feelings of restlessness
61. Becoming easily fatigued
62. Experiencing shortness of breath or feeling smothered
63. Experiencing a pounding or racing heartbeat
64. Sweating or having cold, clammy hands
65. Experiencing dry mouth
66. Experiencing dizziness or lightheadedness
67. Having nausea, diarrhea or other abdominal distress
68. Having hot or cold flashes
69. Having to urinate frequently
70. Having trouble swallowing or feeling a "lump in your throat"
71. Feeling keyed up or on edge
72. Being quick to startle or feeling jumpy
73. Finding it difficult to concentrate, or having your "mind go blank"
74. Having trouble falling or staying asleep
75. Experiencing irritability
76. Having trouble sustaining attention or being easily distracted
77. Experiencing difficulty completing projects
78. Feeling overwhelmed by the tasks of everyday living
79. Having trouble maintaining an organized work or living area
80. Being inconsistent in work performance
81. Lacking in attention to detail

Other Self

82. Making decisions impulsively
83. Having difficulty delaying what you want, having to have your needs met immediately
84. Feeling restless and/or fidgety
85. Making comments to others without considering their impact
86. Being impatient and/or easily frustrated
87. Experiencing frequent traffic violations or near accidents
88. Refusing to maintain body weight above a level that most people consider healthy
89. Intensely fearing gaining weight or becoming fat even though underweight
90. Having feelings of being fat, even though you're underweight
91. Experiencing recurrent episodes of binge eating large amounts of food
92. Feeling of lack of control over eating behavior
93. Engaging in regular activities to purge binges, such as self-induced vomiting, laxatives, diuretics, strict dieting, or strenuous exercise
94. Being overly concerned with body shape and/or weight
95. a.Experiencing involuntary physical movements and/or motor tics (such as eye blinking, shoulder shrugging, head jerking or picking). How long have tics been present?

    How often? Please describe

95b. Experiencing involuntary vocal sounds or verbal tics (such as coughing, puffing, blowing, whistling, or swearing). How long have tics been present?

    How often? Please describe

96. Having delusional or bizarre thoughts (thoughts you know others would think are false)
97. Seeing objects, shadows or movements that are not real
98. Hearing voices or sounds that are not real
99. Experiencing periods of time where your thoughts or speech were disjointed or didn't make sense to you or others
100. Feeling socially isolated or withdrawn
101. Having a severely impaired ability to function at home or at work
102. Behaving peculiarly
103. Lacking personal hygiene or grooming
104. Being in an inappropriate mood for a given situation (e.g., laughing at sad events)
105. Having a marked lack of initiative
106. Having frequent feelings that someone or something is out to hurt you or discredit you

Other Self

107. Snoring loudly (or others complaining about your snoring)
108. Others saying that you stop breathing when you sleep
109. Feeling fatigued or tired during the day
110. Often feeling cold when others feel fine or they are warm
111. Often feeling warm when others feel fine or they are cold
112. Having problems with brittle or dry hair
113. Having problems with dry skin
114. Having problems with sweating
115. Having problems with chronic anxiety or tension
116. Having impairment in communication as manifested by at least one of the following (please circle all that apply):
    - A delay in or total lack of the development of spoken language (not accompanied by an attempt to compensate);
    - In individuals with adequate speech, having a marked impairment in the ability to initiate or sustain a conversation with others;
    - The repetitive use of language, or the use of odd language;
    - A lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level.
117. Having an impairment in social interaction, with at least two of the following (please circle all that apply):
    - A marked impairment in the use of multiple nonverbal behaviors such as eye- to-eye gaze, facial expression, body postures, and gestures to regulate social interaction;
    - A failure to develop peer relationships appropriate to developmental level;
    - A lack of spontaneously seeking to share enjoyment, interests, or achievements with other people (e.g., by a lack of showing, bringing, or pointing out objects of interest);
    - A lack of social or emotional reciprocity.
118. Having repetitive patterns of behavior, interests, and activities, as manifested by at least one of the following (please circle all that apply):
    - A preoccupation with an area that is abnormal either in intensity or focus;
    - A rigid adherence to specific, nonfunctional routines or rituals;
    - Repetitive motor mannerisms (e.g., hand or finger flapping or twisting, or complex whole-body movements);
    - A persistent preoccupation with parts of objects.

AMEN BRAIN SYSTEM CHECKLIST | Copyright Daniel G. Amen, MD

Please rate yourself on each of the symptoms listed below using the following scale. If possible, to give us the most complete picture, have another person who knows you well (such as a spouse, partner or parent) rate you as well. List the person's relationship to you:

0| Never 1| Rarely 2| Occasionally 3| Frequently 4| Very Frequently NA| Not Applicable

Other Self

1. Failing to give close attention to details or making careless mistakes
2. Having trouble sustaining attention in routine situations (e.g., homework, chores, paperwork)
3. Having trouble listening
4. Failing to finish things
5. Having poor organization for time or space (such as a backpack, room, desk, paperwork)
6. Avoiding, disliking, or being reluctant to engage in tasks that require sustained mental effort
7. Losing things
8. Being easily distracted
9. Being forgetful
10. Having poor planning skills
11. Lacking clear goals or forward thinking
12. Having difficulty expressing feelings
13. Having difficulty expressing empathy for others
14. Experiencing excessive daydreaming
15. Feeling bored
16. Feeling apathetic or unmotivated
17. Feeling tired, sluggish or slow moving
18. Feeling spacey or "in a fog"
19. Feeling fidgety, restless or trouble sitting still
20. Having difficulty remaining seated in situations where remaining seated is expected
21. Running about or climbing excessively in situations in which it is inappropriate
22. Having difficulty playing quietly
23. Being always "on the go" or acting as if "driven by a motor"
24. Talking excessively

Other Self

25. Blurting out answers before questions have been completed
26. Having difficulty waiting.
27. Interrupting or intruding on others (e.g., butting into conversations or games)
28. Behaving impulsively (saying or doing things without thinking first)
29. Worrying excessively or senselessly
30. Getting upset when things do not go your way
31. Getting upset when things are out of place
32. Tending to be oppositional or argumentative
33. Tending to have repetitive negative thoughts
34. Tending toward compulsive behaviors (i.e., things you feel you must do)
35. Intensely disliking change
36. Tending to hold grudges
37. Having trouble shifting attention from subject to subject
38. Having trouble shifting behavior from task to task
39. Having difficulties seeing options in situations
40. Tending to hold on to own opinion and not listen to others
41. Tending to get locked into a course of action, whether or not it is good
42. Needing to have things done a certain way or else becoming very upset
43. Others complaining that you worry too much
44. Tending to say no without first thinking about the question
45. Tending to predict fear
46. Experiencing frequent feelings of sadness
47. Having feelings of moodiness
48. Having feelings of negativity
49. Having low energy
50. Being irritable
51. Having a decreased interest in other people
52. Having a decreased interest in things that are usually fun or pleasurable
53. Having feelings of hopelessness about the future
54. Having feelings of helplessness or powerlessness
55. Feeling dissatisfied or bored

Other Self

56. Feeling excessive guilt
57. Having suicidal feelings
58. Having crying spells
59. Having lowered interest in things that are usually considered fun
60. Experiencing sleep changes (too much or too little)
61. Experiencing appetite changes (too much or too little)
62. Having chronic low self-esteem
63. Having a negative sensitivity to smells/odors
64. Frequently feeling nervous or anxious
65. Experiencing panic attacks
66. Symptoms of heightened muscle tension (such as headaches, sore muscles, hand tremors, etc.)
67. Experiencing periods of a pounding heart, a rapid heart rate, or chest pain
68. Experiencing periods of troubled breathing or feeling smothered
69. Experiencing periods of dizziness, faintness, or feeling unsteady on your feet
70. Feeling nausea or having an upset stomach
71. Experiencing periods of sweating, hot flashes, or cold flashes
72. Tending to predict the worst
73. Having a fear of dying or doing something crazy
74. Avoiding places for fear of having an anxiety attack
75. Avoiding conflict
76. Excessively fearing being judged or scrutinized by others
77. Having persistent phobias
78. Having low motivation
79. Having excessive motivation
80. Experiencing tics (either motor or vocal)
81. Having poor handwriting
82. Being quick to startle
83. Having a tendency to freeze in anxiety-provoking situations
84. Lacking confidence in own abilities
85. Feeling shy or timid
86. Being easily embarrassed

Other Self

87. Being sensitive to criticism
88. Biting fingernails or picking at skin
89. Having a short fuse or experiencing periods of extreme irritability
90. Having periods of rage with little provocation
91. Often misinterpreting comments as negative when they are not
92. Finding that own irritability tends to build, then explodes, then recedes, often being tired after a rage
93. Having periods of spaciness and/or confusion
94. Experiencing periods of panic and/or fear for no specific reason
95. Experiencing visual and/or auditory changes, such as seeing shadows or hearing muffled sounds
96. Having frequent periods of déjà vu (that is, feelings of being somewhere you have never been)
97. Being sensitive or mildly paranoid
98. Experiencing headaches or abdominal pain of uncertain origin
99. Having a history of a head injury, or having a family history of violence/explosiveness
100. Having dark thoughts, ones that may involve suicidal or homicidal thoughts
101. Experiencing periods of forgetfulness or memory problems

AMEN CLINIC LEARNING DISABILITY SCREENING QUESTIONNAIRE

Please rate yourself on each of the symptoms listed below using the following scale. If possible, to give us the most complete picture, have another person who knows you well (such as a spouse, partner or parent) rate you as well. List the person's relationship to you:

0| Never 1| Rarely 2| Occasionally 3| Frequently 4| Very Frequently NA| Not Applicable

Reading

Other Self

1. I am a poor reader.
2. I do not like reading.
3. I make mistakes when reading, such as skipping words or lines.
4. I read the same line twice.
5. I have problems remembering what I read even though I have read all the words.
6. I reverse letters when I read (such as b/d, p/q).
7. I switch letters in words when reading (such as god and dog).
8. My eyes hurt or water when I read.
9. Words tend to blur when I read.
10. Words tend to move around the page when I read.
11. When reading I have difficulty understanding the main idea or identifying important details.

Writing

Other Self

12. I have "messy " handwriting.
13. My work tends to be messy.
14. I prefer to print rather than to write in cursive.
15. My letters run into each other or there is no space between words.
16. I have trouble staying within lines.
17. I have problems with grammar or punctuation.
18. I am a poor speller.
19. I have trouble copying off the board or from a page in a book.
20. I have trouble getting thoughts from my brain to the paper.
21. I can tell a story but cannot write it.

Body Awareness/ Spatial Relationships

Other Self

22. I have trouble with knowing my left from my right.
23. I have trouble keeping things within columns or coloring within lines.
24. I tend to be clumsy, uncoordinated.
25. I have difficulty with eye/hand coordination.
26. I have difficulty with concepts such as up, down, over, or under.
27. I tend to bump into things when walking.

Oral Expressive language

Other Self

28. I have difficulty expressing myself in words.
29. I have trouble finding the right word to say in conversations.
30. I have trouble talking around a subject or getting to the point in conversations.

Receptive language

Other Self

31. I have trouble keeping up or understanding what is being said in conversations.
32. I tend to misunderstand people and give the wrong answers in conversations.
33. I have trouble understanding directions people tell me.
34. I have trouble telling the direction sound is coming from.
35. I have trouble filtering out background noises.

Math

Other Self

36. I am poor at basic math skills for my age (adding, subtracting, multiplying, and dividing)
37. I make “careless mistakes” in math.
38. I tend to switch numbers around.
39. I have difficulty with word problems.

Sequencing

Other Self

40. I have trouble getting everything in the right order when I speak.
41. I have trouble telling time.
42. I have trouble using the alphabet in order.
43. I have trouble saying the months of the year in order.

Abstraction

Other Self

44. I have trouble understanding jokes people tell me.
45. I tend to take things too literally.

Organization

Other Self

46. My notebook/paperwork is messy or disorganized.
47. My room is messy.
48. I tend to shove everything into my backpack, desk or closet.
49. I have multiple piles around my room.
50. I have trouble planning my time.
51. I am frequently late or in a hurry.
52. I often do not write down assignments or tasks and end up forgetting what to do.

Memory

Other Self

53. I have trouble with my memory.
54. I remember things from long ago but not recent events.
55. It is hard for me to memorize things for school or work.
56. I know something one day but do not remember it the next day.
57. I forget what I am going to say right in the middle of saying it.
58. I have trouble following directions that have more than one or two steps.

Social Skills

Other Self

59. I have few or no friends.
60. I have trouble reading the body language or facial expressions of others.
61. My feelings are often or easily hurt.
62. I tend to get into trouble with friends, teachers, parents, or bosses.
63. I feel uncomfortable around people whom I do not know well.
64. I am teased by others.
65. Friends do not call and ask me to do things with them.
66. I do not get together with others outside of school or work.

Scotopic Sensitivity

Other Self

67. I am light sensitive. Bothered by glare, sunlight, headlights or streetlights.
68. I become tired and/or experience headaches, mood changes, feel restless, or have an inability to stay focused with bright or fluorescent lights.
69. I have trouble reading words that are on white, glossy paper.
70. When reading, words or letters shift, shake, blur, move, run together, disappear, or become difficult to perceive.
71. I feel tense, tired, sleepy, or even get headaches with reading.
72. I have problems judging distance and have difficulty with such things as escalators, stairs, ball sports, or driving.

Sensory Integration Issues

Other Self

73. I seem to be more sensitive to the environment than are other people.
74. I am more sensitive to noise than are other people.
75. I am particularly sensitive to touch or very sensitive to certain clothing or tags on the clothing.
76. I have an unusual sensitivity to certain smells.
77. I have an unusual sensitivity to light.
78. I am sensitive to movement or crave spinning activities.
79. I tend to be clumsy or accident-prone.

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

1. Over the last two weeks, how often have you been bothered by the following problems?

0| Never 1| Several Days 2| More Than Half The Days 3| Nearly Every Day

1. Little interest or pleasure in doing things
2. Feeling down, depressed, or hopeless
3. Trouble falling or staying asleep, or sleeping too much
4. Feeling tired or having little energy
5. Poor appetite or overeating
6. Feeling bad about yourself- or that you are a failure or have let yourself or your family down
7. Trouble concentrating on things, such as reading the newspaper or watching television
8. Moving or speaking so slowly that other people could have noticed. Or the opposite- being so fidgety or restless that you have been moving around a lot more than usual
9. Thoughts that you would be better off dead, or of hurting yourself

2. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Never Somewhat Difficult Very Difficult Extremely Difficult