Intake Form for Diagnosing and Treating Bipolar II/Subthreshold Bipolar
by Tammas Kelly MD

In a few short words or sentences please state the reason you are seeking consultation or treatment.

PERSONAL HISTORY FORM

Date of appointment_____

Prior to your evaluation this form must be completely filled out. The information you provide will help me help you. Much of what you need is readily available but some may take an effort to obtain. Family history may need to be obtained from parents. Please bring any old records or labs with you to your appointment.

NAME_____ Address_____ City_____

State_____ Zip _____Occupation_____ Home Phone _____

DOB_____ Cell Phone_____

Age_____ Work_____ Ext. _____ E-mail_____

Emergency Contact_____ Address_____ City _____

State_____ Zip_____ Phone Home_____ Work_____ Ext._____

Person filling out form, if not patient _____ Patient's SSN #_____

Who referred you (circle one) Friend Insurance Primary Care MD Other MD Therapist Other_____

Primary Physician _____ Address_____

City_____ State_____ Zip _____ Phone_____

Therapist _____ Address_____

City_____ State_____ Zip _____ Phone_____

Fax_____ Date of last appointment _____

In a few short words or sentences please state your goals in life. What do you want in life? Examples: Being happy, being stable, going to college, keeping your job, keeping your marriage etc.

Please list <u>all</u> of your present prescription medications:
List strength and how often you take them. Side Effects:

Please list <u>all</u> of your present herbs, vitamins and over the counter medications:

What medications are you allergic to?

None

1. _____
2. _____
3. _____

Weight_____ Maximum all time Weight_____ Height_____ Feet _____inches

<u>Known or suspected medical conditions:</u>

The following 6 pages ask about past psychiatric medications. Please fill out this section with as much information as you can remember or find. Your response to medications good, bad or side effects will help guide me with future treatments. If you have not been on a medication before please circle no.

Brand Name/ Generic Name	**When & How Long** **Circle No if never took**	**Results**	**Side Effects**	**Why Quit** **Highest Dose**
Antidepressents:				
Paxil/ Paxil CR Paroxentine	No			
Effexor/ Venlafaxine	No			
Effexor XR/ Venlafaxine XR	No			
Wellbutrin/ Bupropion	No			
Wellbutrin SR/ Bupropion SR	No			
Wellbutrin XL/ Bupropion XL	No			
Zyban/ Bupropion SR	No			
Cymbalta/ Duloxetine	No			
Zoloft/ Sertraline	No			
Prozac/Fluoxetine	No			
	No			

Brand Name/ Generic Name	**When & How Long** **Circle No if never took**	**Results**	**Side Effects**	**Why Quit** **Highest Dose**
Antidepressents Continued:				
Luvox/ Fluvoxamine	No			
Celexa/ Citalopram	No			
Anafranil/ Clomipramine	No			
Tofranil/ Imipramine	No			
Pamelor/ Nortriptyline	No			
Elavil/ Amitriptyline	No			
Norpramin/ Desipramine	No			
Lexapro/ Escitalopram	No			
Vivactal/ Protriptlyne	No			
Ludiomil/ Maprotiline	No			
Remeron/ Mirtazapine	No			
Sinequan/ Doxepin	No			
Asendin/ Amoxipine	No			
Nardil/ Phenelzine	No			
Parnate/ Tranylcypromine	No			
Cymbalta/ Duloxetine	No			
Viibryd/vilazodone	No			

Brand Name/ Generic Name	When & How Long Circle No if never took	Results	Side Effects	Why Quit Highest Dose
Mood Stabilizers:				
Eskalith/Eskalith CR Lithium	No			
Lithobid/ Lithium	No			
Depakote/ Depakene	No			
Depakote Depakote ER	No			
Depakene Valproic Acid	No			
Lamictal/ Lamotrigine	No			
Neurontin/ Gabapentin	No			
Topomax/ Topiramate	No			
Trileptal/ Oxcarbazepine	No			
Calan/ Calan CR Verapamil	No			
Tegretol Carbamazepine	No			
Carbitrol Equatro Tegritol XL	No			
Brintellix/ vortioxetine	No			
Pristiq/ desvenlafaxine	No			
Fetzima/ levomilnacipran	No			
Saphris/asenapine	No			

Brand Name/ Generic Name	**When & How Long** **Circle No if never took**	**Results**	**Side Effects**	**Why Quit/ Highest Dose**
Anxiety/Sleeping Medications:				
Ambien/ Zolpidem	No			
Prosom/ Estazolam	No			
Dalmane/ Flurazepam	No			
Doral/ Quazepam	No			
Restoril/ Temazepam	No			
Halcion/ Triazolam	No			
Chloral Hydrate	No			
Lunesta/ Eszopiclone	No			
Buspar/ Buspirone	No			
Vistaril/ Hydroxyzine	No			
Ativan/ Lorazepam	No			
Xanax/ Alprazolam	No			
Klonopin/ Clonazepam	No			
Librium/ Chlordiazepoxide	No			
Atarax/ Hydroxyzine	No			
	No			

Brand Name/ Generic Name	When & How Long Circle No if never took	Results	Side Effects	Why Quit/ Highest Dose
Anxiety/Sleeping Medications Continued:				
Tranxene/ Clorazepate	No			
Valium/ Diazepam	No			
Serax/ Oxazepam	No			
Miscellaneous:				
Co Q 10	No			
Nemenda/ Memantine	No			
N-Acetyl Cystine	No			
Provigil/Nuvigil Modafinil	No			
Stimulants/Medications to treat ADD/ADHD:				
Medications for ADHD or ADD	No			
Adderall Adderall XR	No			
Dexedrine/ Dextroamphetamine	No			
Cylert/ Pemoline	No			
Ritalin/ Methylphenidate	No			
Strattera/ Atomoxetine	No			
	No			

Brand Name/ Generic Name	**When & How Long** **Circle No if never took**	**Results**	**Side Effects**	**Why Quit** **Highest Dose**
Haldol/ Haloperidol	No			
Thorazine/ Chlorpromazine	No			
Mellaril/ Thioridazine	No			
Prolixin/ Fluphenazine	No			
Trilafon/ Perphenazine	No			
Serentil/ Mesoridazine	No			
Loxitane/ Loxapine	No			
Moban/ Molindone	No			
Risperdal/ Risperidone	No			
Zyprexa/ Olanzapine	No			
Seroquel/ Quetiapine	No			
Geodon/ Ziprazidone	No			
Abilify/ Aripiprazole	No			
CAPLYTA/ lumateperone	No			
Latuda/lurasdone	No			
Fanapt/iloperidone	No			
Invega/paliperidone	No			
Rexulti/brexpiprazl	No			
Saphris/asenapine	No			

Review of Systems

Do you smoke or chew tobacco? How much? _____ Packs per day or cans per week.

Do you use Caffeine containing beverages? Yes í No í

How many cups of coffee or tea a day? _____ Size of cups? _____oz.

Cans of pop a day or equivalent? _____

	Last 6 weeks		Life time	
Do you worry you might have a problem with Alcohol or drugs?	Yes	No	Yes	No
Has anyone else ever worried you have a problem with Alcohol or drugs?	Yes	No	Yes	No
Have you ever tried to cut back on your use of Alcohol or drugs?	Yes	No	Yes	No
Have you ever been intoxicated and drove?	Yes	No	Yes	No
How many drinks or use of drugs do you consume in an average day?	_____		_____	
In the last year what is the most you have drank or used in 24 hours?	_____		_____	
Do you experience times during drinking or using that you can't remember?	Yes	No	Yes	No
Binge drink or drug?	Yes	No	Yes	No
Have you ever been charged with DUI or public intoxication ?	Yes	No	Yes	No

When was the last time you had 4 or more drinks in 1 day?_____

Have you used the following substances? íNo If yes check those used.

Marijuana	Mushrooms
Cocaine	Heroin
Salvia	Morphine
Amphetamines	Fentanyl
Crystal Meth	PCP
Ecstasy	Ketamine
LSD	Inhalants (paint, gas, white-out, glue, others)

Head Injury:

Have you ever hit your head or been hit in the head hard enough to that you lost consciousness or been confused afterwards? Yes No

If yes how long were you unconscious or confused? _____ When?_____

Sleep:

Are you having any trouble getting to sleep? Yes No

On the average how long does it take you to get to sleep? _____

Do you awaken during the night? Yes No

How many times?_____

How long does it take you to get back to sleep? _____

What is the longest period of time that you have gone without sleep_____

Sleep Continued…

1. Are you significantly overweight? Yes No
2. If male, is your neck size greater than 17 inches? Yes No
3. If female, is your neck size greater than 16 inches? Yes No
4. Do you snore most nights or on a nightly basis? Yes No
5. Has your snoring been heard in other rooms or forced your partner into another room? Yes No
6. Have you been observed gasping or not breathing while you sleep? Yes No
7. Do you awaken during the night choking or gasping for air? Yes No
8. In the morning, do you wake with headaches and or nasal congestion? Yes No
9. Are you frequently sleepy during the day on a regular basis? Yes No
10. Has your sleepiness interfered with your life? Yes No

Do you at times experience any of the following?

Please rate in each area:	None	Mild	Moderate	Severe
Trembling, twitching or feeling shaky				
Muscle tension				
Restlessness				
Heart racing				
Sweating				
Clammy hands				
Dry mouth				
Dizziness				
Feeling light headed				
Nausea				
Diarrhea				
Stomach pains				
Frequent urination				
Trouble swallowing or lump in-throat				
Feeling keyed up or on the edge				
Startle easily				
Irritability				
Agitation				

Do you ever have <u>sudden</u> onset of

	Last 6 Months	**Life Tim**
Anxiety	Yes No	Yes No
Fear of dying	Yes No	Yes No
Fear of going crazy	Yes No	Yes No
Chest pain or discomfort	Yes No	Yes No
Nausea or abdominal discomfort	Yes No	Yes No
Shortness of breath	Yes No	Yes No
Dizziness or faintness	Yes No	Yes No
Heart racing	Yes No	Yes No
Trembling or shaking	Yes No	Yes No
Sweating	Yes No	Yes No
Tingling fingers	Yes No	Yes No
Hot flashes or chills	Yes No	Yes No
Feeling not real	Yes No	Yes No

Have you ever had trouble with your thinking?

Has your thinking ever been so confused that you lost track of your ideas? Yes No

Have you ever felt like people were watching or following you, or that they wanted to hurt you? Yes No

Have your eyes ever played tricks on you? Yes No

Have you ever had the experience of hearing a voice when nobody else was around? Yes No

Have you ever had the experience of seeing things that weren't there? Yes No

How many depressive episodes have you had in you life (please give your best estimate)? _____

Average length of depression(s) _____ Length of longest depression _____ Length of shortest depression _____

At what age did you first experience depression any depression? _____

At what age do you first remember having significant anxiety?_____

When you are depressed how many hours do you sleep?_____

Does your mood vary between AM and PM? Yes No How? _____

What times) of year does your mood worsen? Winter Spring Summer Fall

Instructions: Please answer each question as best you can.

1. Has there ever been a period of time when you were not your usual self and...	**Last year**		**Life time**	
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble? ……..Yes	No	Yes	No	
...you were so irritable that you shouted at people or started fights or arguments……Yes	No	Yes	No	
...you felt much more self-confident than usual?……..Yes	No	Yes	No	
...you got much less sleep than usual and found you didn't really miss it?……Yes	No	Yes	No	
...you were much more talkative?……...Yes	No	Yes	No	
you spoke much faster than usual?……...Yes	No	Yes	No	
...thoughts raced through your head or you couldn't slow your mind down?……Yes	No	Yes	No	
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?.....Yes	No	Yes	No	
...you had much more energy than usual?……..Yes	No	Yes	No	
...you were much more active or did many more things than usual?……Yes	No	Yes	No	
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?.....Yes	No	Yes	No	
...you were much more interested in sex than usual?……..Yes	No	Yes	No	
...spending money got you or your family into trouble?……Yes	No	Yes	No	
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?.....Yes	No	Yes	No	

If you answered yes what things did you do?_____

Do you have days of energy or ideas that come and go abruptly? Yes No

	Over the last 12 month have you…	Over your life time...
...been much more energetic?	yes no	yes no
…been more active?	yes no	yes no
...been less easily tired?	yes no	yes no
...needed less sleep?	yes no	yes no
...been more talkative?	yes no	yes no
...traveled around more?	yes no	yes no
...been busier etc.?	yes no	yes no
...acted out your anger against another	yes no	yes no
...been more impulsive	yes no	yes no
...had financial difficulties caused by over spending	yes no	yes no

Was this so evident that you had problems with it yourself, it caused you problems with others, could have caused you problems if it had become known, or it got you into financial difficulties? yes no NA

Did other people (e.g., family members, partner, etc.) notice these states in you and are worried that something was not right ?

	yes	no	NA
Would you say you were one of those people who have ups and downs?	yes	no	NA
Would other people think so?	yes	no	NA
Would you say you were one of those people who have mood swings?	yes	no	NA
Would other people think so?	yes	no	NA

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Symptoms list Please circle answers.	Easily distractible (jumping from topic to topic)
More strength	More irritable or impatient
More self-confidence	More energy
More enthusiasm for work	Made impulsive decisions
More social activities (more phone calls, more visits)	Started a project and later just didn't have the energy to carry it through
More travel	More (careless) driving
Overspending	Consumed more coffee, cigarettes, drugs or alcohol
Risky business activities	Binged on coffee, cigarettes, drugs or alcohol
More physical activity (moving about more)	Euphoric, overoptimistic
More plans and ideas	More sexual interest or activity
Less shy, less inhibited	Spontaneously start conversation with strangers in public places
More talkative than usual	Talking faster
Thinking faster	Racing thoughts
More sudden ideas	Crowded thoughts
More puns and jokes	
	None of the above

How often did such changes (episodes) occur in the last 12 months?

once

2 or 3 times

4 to 6 times

8 to 11 times

once or twice a month

once a week

almost every day

several times a day

several times a day

several times a day

What was the longest duration that you experienced such changes/problems ?

1 day

2 days

3 days

4 to 6 days

1 week or more

2 weeks or more

1 month or more

3 months or more

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
Little interest in doing things				
Little pleasure in doing things				
Feeling down				
Feeling depressed				
Feeling hopeless				
Trouble falling asleep				
Trouble staying asleep				
Feeling sleepy (other than expected sleep times)				
Feeling low energy				
Poor appetite				
Feeling bad about yourself, or feeling that you are a failure or have let yourself or your family down				
Trouble concentrating on things such as reading the newspaper or watching television				
Moving or speaking so slowly that other people notice				
Being so fidgety or restless that you have been moving around a lot more than usual				
Thinking that you would be better off dead or you wouldn't mind it if you died				
Memory problems				
Wanting to hurt yourself in some way or suicide				
Mood brightens to actual or potential events				
Mood quickly worsens to actual or potential events				
Weight gain				
Increased appetite				
Sleep too much (If yes how many hours?) _____				
Feel like you have heavy leaden arms or legs				
Some times I am a very sensitive person at times				
Other times I am not sensitive at all				

In general, how would you describe your relationship?

■ a lot of tension ■ some tension ■ no tension

Do you and your partner work out arguments with

■ great difficulty ■ some difficulty ■ no difficulty

Weight_____ Height____ Feet_____ Inches_____

Maximum weight gain?_____ Maximum Weight loss?_____

Fire Arms

Do you have any guns at home? Yes No

If yes how are they stored? _____

Suicide Attempts If more than 3 please use blank paper.

1. When? _____ Planned or spur of the moment?

How/method? _____

Why? _____

How were you stopped/ found? _____

Were you medically hospitalized? _____How Long?_____

Were you psychiatrically hospitalized ? _____ How Long? _____

What was your follow up care?_____

2. When? _____ Planned or spur of the moment?

How/method? _____

Why? _____

How were you stopped/ found? _____

Were you medically hospitalized? _____How Long?_____

Were you psychiatrically hospitalized ? _____ How Long? _____

What was your follow up care?_____

What is the most traumatic event you have ever experienced?

_____

_____

_____

Do you often think of this experience? Yes ☐ No ☐

Do you have recurrent dreams that might be related to this event? Yes ☐ No ☐
Feeling that the event is happening to you again? Yes ☐ No ☐

No.		Not at all (1)	A little bit (2)	Moderately (3)	Quite a bit (4)	Extremely (5)
1.	Repeated, disturbing *memories, thoughts,* or *images* of a stressful experience from the past?					
2.	Repeated, disturbing *dreams* of a stressful experience from the past?					
3.	Suddenly *acting* or *feeling* as if a stressful experience *were happening again* (as if you were reliving it)?					
4.	Feeling *very upset* when *something reminded* you of a stressful experience from the past?					
5.	Having *physical reactions* (e.g., heart pounding, trouble breathing, or sweating) when *something reminded* you of a stressful experience from the past?					
6.	Avoid *thinking about* or *talking about* a stressful experience from the past or avoid *having feelings* related to it?					
7.	Avoid *activities* or *situations* because *they remind you* of a stressful experience from the past?					
8.	Trouble *remembering important parts* of a stressful experience from the past?					
9.	Loss of *interest in things that you used to enjoy?*					
10.	Feeling *distant* or *cut off* from other people?					
11.	Feeling *emotionally numb* or being unable to have loving feelings for those close to you?					
12.	Feeling as if your *future* will somehow be *cut short*?					
13.	Trouble *falling* or *staying asleep*?					
14.	Feeling *irritable* or having *angry outbursts*?					
15.	Having *difficulty concentrating*?					
16.	Being *"super alert"* or watchful on guard?					
17.	Feeling *jumpy* or easily startled?					

Family History/Past Diagnosis

Please answer the following family history. Blood relatives only no one only related by marriage only. Please mark for each category even if the answer is none. Use the following abbreviations:

Paternal = Father's side Maternal = Mother's side
If you have been Diagnosed in past use: Me
Mother: M **Brother: B (B1, B2, B3...)**
Father: F **Sister: S (S1,S2…)**
Child: Name of child
Maternal Cousin: MC (Please mark MC1, MC2, MC3...)
Paternal Cousin: PC
Maternal Uncle: MU (Please mark MU1, MU2, MU3...)
Maternal Aunt: MA
Paternal Uncle: PU **Paternal Aunt: PA**
Maternal Grandmother: MGM **Paternal Grandmother: PGM**
Maternal Grandfather: MGF **Paternal Grandfather: PGF**
Maternal Great Grandfather: MGGF **Paternal Great Grandfather: PGGF**
Maternal Great Grandmother: MGGM **Paternal Great Grandmother: PGGM**
Maternal Grand Aunt: MGA **Paternal Grand Aunt: PGA**
Maternal Grand Uncle: MGU **Paternal Grand Uncle: PGU**
Paternal Grand Aunt: PGA

Who in your family do you resemble as far as mood or temperament is concerned (Can be more than one)

_____

How much do you know about your families mental illness history?

None Very Little Little Moderate Quite a lot Everything

	Known	Suspected
Schizophrenia or Schizoaffective disorder		
Manic-depression		
Bipolar Disorder I		
Bipolar Disorder II		
Bipolar Disorder NOS		
Bipolar Spectrum Disorder		
Attention Deficit/HyperActivity Disorder		
Alcoholic/Alcoholism		

Family History Continued:		
	Known	**Suspected**
Depression		
Major Depression		
Alzheimer's		
Dementia		
Tourette's		
Oppositional Defiant Disorder		
Conduct Disorders		
Panic Disorder		
Anxiety Disorder		
Obsessive Compulsive Disorder		
Post Traumatic Stress Disorder		
Social Anxiety Disorder		
Insomnia		
Sleep problems		
Paranoia		
Drunk Driving (even if not caught)		
Hallucinations/Delusions		
Anorexia		
Bulimia		
Binge Eating		
Suicide/suicide attempts		
Psychiatric Hospitalization		
ECT, Electroconvulsive therapy.		

Family History Continued:		
	Known	**Suspected**
Mood Swings		
Periods of being hyper		
Periods of high energy		
Periods of sleeping little-Less than 7 hours		
Periods of my self-confidence		
Periods of a lot of activity		
Irritability/Temper problems		
Talking fast or talking a lot		
Multiple marriages		
Multiple jobs		
Took mood stabilizers		
Trouble holding jobs		
Critical		
PMS/late Luteal Phase Dysphoric disorder		
TMS (Transcranial magnetic stimulation)		
Worried a lot		
Anxious person		
Had a lot of fears		
Periods of low energy		
Periods of sleeping a lot		
Took antidepressants		

Family History Continued:		
	Known	**Suspected**
Sleep Apnea		
Thyroid Problems		
Diabetes		
Heart Troubles		
Heart Attack		
High Blood Pressure or Hypertension		
Stroke		
Epilepsy		
Asthma		
Allergies		
Liver Disease		
Migraine Headaches		
Emphysema		
Ulcers		
Kidney Disease		
Glaucoma		
Anemia		
Sickle Cell Anemia		
Cancer or Leukemia		
Tuberculosis		

Family History Continued:		
	Known	**Suspected**
Were Physical Abused		
Were Sexually Abused		
Was Raped		
Sexually Abusive=Specify to who		
Dysthymia		
Never happy		
Critical		
Marijuana Dependence/ Problems		
Cocaine Dependence/ Problems		
Amphetamine Dependence/ Problems		
Difficulties with the law		
Incarceration		
Assaultive behavior		
Domestic Violence		
Never seemed happy		
Borderline Personality Disorder		
Antisocial		
Narcissistic		
Dependent personality traits		

Please circle yes or no for each of the following answer based on the last month

1. Do you have concerns with contamination (dirt, germs, chemicals, radiation) or getting a serious illness such as AIDS?.....yes no
2. Are you overconcerned with keeping objects (clothing, groceries, tools) in perfect order or arranged exactly?.....yes no
3. Do you have mental images of death or other horrible events?.....yes no
4. Do you have personally unacceptable religious or sexual thoughts?.....yes no
5. Do you worry about fire, burglary, or flooding the house?.....yes no
6. Do you worry about accidentally hitting a pedestrian with your car or letting it roll down the hill?.....yes no
7. Do you worry about spreading an illness (i.e. giving someone AIDS)?.....yes no
8. Do you worry about losing something valuable?.....yes no
9. Do you worry about harm coming to a loved one because you weren't careful enough?.....yes no
10. Are you concerned about physically harming a loved one, pushing a stranger in front of a bus, steering your car into oncoming traffic; inappropriate sexual contact; or poisoning dinner guests?.....yes no
11. Do you perform excessive or ritualized washing, cleaning, or grooming rituals?.....yes no
12. Do you check light switches, water faucets, the stove, door locks, or your car's emergency brake?.....yes no
13. Do you perform counting; arranging; "evening-up" behaviors (making sure socks are at same height)?.....yes no
14. Do you collect useless objects or inspect the garbage before it is thrown out?.....yes no
15. Do you repeat routine actions (going in/out of a chair, going through a doorway, re-lighting a cigarette) a certain number of times, or until it feels "just right?"
16. Do you need to touch objects or people?.....yes no
17. Do you unnecessarily re-read or re-write; re-open envelopes before they are mailed?.....yes no
18. Do you examine your body for signs of illness?.....yes no
19. Do you avoid certain colors ("red" means blood), numbers ("l3" is unlucky), or names (those that start with "D" signify death) that are associated with dreaded events or unpleasant thoughts?.....yes no
20. Do you feel a need to "confess" or repeatedly ask for reassurance that you said or did something correctly?.....yes no

On average, how much time is occupied by these thoughts or behaviors each day? _____hours

How much distress do they cause you? None Mild Moderate Severe Extreme

How difficult is it for you to control them? None Mild Moderate Severe Extreme

How much do they interfere with school, work or your social or family life?
None Mild Moderate Severe Extreme

1. Did you ever lose time from work or school due to gambling?.....yes no
2. Has gambling ever made your home life unhappy?.....yes no
3. Did gambling affect your reputation?.....yes no
4. Have you ever felt remorse after gambling?.....yes no
5. Did you ever gamble to get money with which to pay debts or otherwise solve financial difficulties?.....yes no
6. Did gambling cause a decrease in your ambition or efficiency?.....yes no
7. After losing did you feel you must return as soon as possible and win back your losses?.....yes no
8. After a win did you have a strong urge to return and win more?.....yes no
9. Did you often gamble until your last dollar was gone?.....yes no
10. Did you ever borrow to finance your gambling?.....yes no
11. Have you ever sold anything to finance gambling?.....yes no
12. Were you reluctant to use "gambling money" for normal expenditures?.....yes no
13. Did gambling make you careless of the welfare of yourself or your family?.....yes no
14. Did you ever gamble longer than you had planned?.....yes no
15. Have you ever gambled to escape worry or trouble?.....yes no
16. Have you ever committed, or considered committing, an illegal act to finance gambling?....yes no
17. Did gambling cause you to have difficulty in sleeping?.....yes no
18. Do arguments, disappointments or frustrations create within you an urge to gamble?.....yes no
19. Did you ever have an urge to celebrate any good fortune by a few hours of gambling?.....yes no
20. Have you ever considered self destruction or suicide as a result of your gambling?.....yes no

At night do you often feel in your legs:

Tingling	Yes	No
Numbness	Yes	No
Pins and needles	Yes	No
Tiredness	Yes	No
Itching	Yes	No
Uneasiness	Yes	No
Pain	Yes	No
Cramping	Yes	No
Aching	Yes	No
Burning	Yes	No
Creeping	Yes	No
Crawling	Yes	No

How much do you weight? _____Pounds Is this a (circle) A good weight Too much Underweight.

	In Last Year		Life Time	
Do you ever eat a lot of food in a short period?	Yes	No	Yes	No
Do you feel out of control when you do so?	Yes	No	Yes	No
Have you ever used laxatives or vomited to control eating or wieght?	Yes	No	Yes	No
Have you ever been diagnosed with anorexia?	Yes	No	Yes	No
Make yourself SICK when you feel uncomfortably full?	Yes	No	Yes	No
Worry you have lost CONTROL over how much you eat?	Yes	No	Yes	No
Recently lost more than 14 pounds within three months?	Yes	No	Yes	No
Believe you are FAT when others say you are too thin?	Yes	No	Yes	No
Would you say that FOOD dominates your life?	Yes	No	Yes	No

Briefly what stressors are you under at this time?

_____

_____

_____

_____

_____

_____

_

	In The Last year						Over a Life Time					
	Not at all	Just a little	Some-what	Mod-erately	Quite a lot	Very Much	Not at all	Just a little	Some what	Mod-erately	Quite a lot	Very Much
My mind has never been sharper												
I need less sleep than usual												
I have so many plans and new ideas that it is hard for me to work												
I feel a pressure to talk and talk												
I have been particularly happy												
I have been more active than usual												
I talk so fast that people have a hard time keeping up with me												
I have more new ideas than I can han-dle												
I have been irritable												
It's easy for me to think of jokes and funny stories												
I have been feeling like "the life of the party"												
I have been full of energy												
I have been thinking about sex												
I have been particularly playful												
I have been spending too much money												
I find it hard to slow down and stay in one place												

Name of Past Psychiatrists/ Therapists (specify)	Diagnosis Given	When/How Long	Reason Seen
Psychiatric/Drug/ Alcohol Hospitalizations	**Diagnosis Given**	**When/How Long**	**Reasons Admitted**

DIAGNOSED DIFFICULTIES

Do you now, or have you in the past, had any of the following:

Migraines	☐No	☐Yes Have Now	Yes Past
Epilepsy or Convulsions	☐No	☐Yes Have Now	☐Yes Past
Alcohol Related Seizures	☐No	☐Yes Have Now	☐Yes Past
Stroke	☐No	☐Yes Have Now	☐Yes Past
Neurological Problems	☐No	☐Yes Have Now	☐Yes Past
Glaucoma	☐No	☐Yes Have Now	☐Yes Past
Cataracts	☐No	☐Yes Have Now	☐Yes Past
Asthma	☐No	☐Yes Have Now	☐Yes Past
Hay Fever	☐No	☐Yes Have Now	☐Yes Past
Chronic Bronchitis	☐No	☐Yes Have Now	☐Yes Past
Tuberculosis	☐No	☐Yes Have Now	☐Yes Past
Abnormal Chest X-ray	☐No	☐Yes Have Now	☐Yes Past
Heart Murmur as an Adult	☐No	☐Yes Have Now	☐Yes Past
Abnormal EKG	☐No	☐Yes Have Now	☐Yes Past _____
Enlarged Heart	☐No	☐Yes Have Now	☐Yes Past _____
Heart Attack	☐No	☐Yes Have Now	☐Yes Past _____
Angina	☐No	☐Yes Have Now	☐Yes Past _____
High Blood Pressure	☐No	☐Yes Have Now	VYes Past _____
Gall Stones	☐No	☐Yes Have Now	☐Yes Past _____
Hepatitis	☐No	☐Yes Have Now	☐Yes Past _____
Cirrhosis of Liver	☐No	☐Yes Have Now	☐Yes Past _____
Stomach or Duodenal Ulcer	☐No	☐Yes Have Now	☐Yes Past _____
Stomach Problems	☐No	☐Yes Have Now	☐Yes Past _____
Abnormal Stomach X-ray	☐No	☐Yes Have Now	☐Yes Past _____
Colon or Bowel Trouble	☐No	☐Yes Have Now	☐Yes Past _____
Rectal Problems	☐No	☐Yes Have Now	☐Yes Past _____
Hemorrhoids	☐No	☐Yes Have Now	☐Yes Past _____
Serious diarrhea	☐No	☐Yes Have Now	☐Yes Past _____
Kidney or Bladder Infections	☐No	☐Yes Have Now	☐Yes Past _____
Kidney Stones	☐No	☐Yes Have Now	☐Yes Past _____
Other Kidney Disease	☐No	☐Yes Have Now	☐Yes Past _____
Anemia	☐No	☐Yes Have Now	☐Yes Past _____
Poor Blood Clotting	☐No	☐Yes Have Now	☐Yes Past _____
Diabetes	☐No	☐Yes Have Now	☐Yes Past _____
On Insulin	☐No	☐Yes Have Now	☐Yes Past _____
Gout	☐No	☐Yes Have Now	☐Yes Past _____
Overactive Thyroid	☐No	☐Yes Have Now	☐Yes Past _____
Under Active Thyroid	☐No	☐Yes Have Now	☐Yes Past _____
Goiter	☐No	☐Yes Have Now	☐Yes Past _____
Broken Bones	☐No	☐Yes Have Now	☐Yes Past _____
Arthritis	☐No	☐Yes Have Now	☐Yes Past _____
Polio	☐No	☐Yes Have Now	☐Yes Past _____
Phlebitis	☐No	☐Yes Have Now	☐Yes Past _____
Syphilis or V.D.	☐No	☐Yes Have Now	☐Yes Past _____
Gonorrhea	☐No	☐Yes Have Now	☐Yes Past _____
HIV Positive	☐No	☐Yes Have Now	☐Yes Past _____

Have you experienced pain in any of the following:

Head aches	☐No	☐Yes Have Now	☐Yes Past _____
Abdomen	☐No	☐Yes Have Now	☐Yes Past _____
Back	☐No	☐Yes Have Now	☐Yes Past _____
Joint or Limb	☐No	☐Yes Have Now	☐Yes Past _____
Chest or Heart	☐No	☐Yes Have Now	☐Yes Past _____
Rectum	☐No	☐Yes Have Now	☐Yes Past _____
Pain during intercourse	☐No	☐Yes Have Now	☐Yes Past _____
Pain during menstruation	☐No	☐Yes Have Now	☐Yes Past _____
Pain during urination	☐No	☐Yes Have Now	☐Yes Past _____
Any other pain	☐No	☐Yes Have Now	☐Yes Past _____

Have you experienced any: (except during pregnancy)

Nausea	☐No	☐Yes Have Now	☐Yes Past _____
Bloating	☐No	☐Yes Have Now	☐Yes Past _____
Vomiting	☐No	☐Yes Have Now	☐Yes Past _____
Diarrhea lasting more than 10 days	☐No	☐Yes Have Now	☐Yes Past _____
Intolerance to several foods	☐No	☐Yes Have Now	☐Yes Past _____
Sexual indifference	☐No	☐Yes Have Now	☐Yes Past _____
Erectile problems	☐No	☐Yes Have Now	☐Yes Past _____
Ejaculatory problems	☐No	☐Yes Have Now	☐Yes Past _____
Sexual dysfunction	☐No	☐Yes Have Now	☐Yes Past _____
Irregular menstruation	☐No	☐Yes Have Now	☐Yes Past _____
Excessive mensuration bleeding	☐ No	☐Yes Have Now	☐Yes Past _____
Vomiting through out pregnancy	☐No	☐Yes Have Now	☐Yes Past _____
Impaired coordination	☐Yes	☐YesHave Now	☐Yes Past _____
Paralysis	☐No	☐Yes Have Now	☐Yes Past _____
Impaired balance	☐No	☐Yes Have Now	☐Yes Past _____
Weakness in body part	☐No	☐Yes Have Now	☐Yes Past _____
Difficulty swallowing	☐No	☐Yes Have Now	☐Yes Past _____
Lump in throat	☐No	☐Yes Have Now	☐Yes Past _____
Inability to talk normally	☐No	☐Yes Have Now	☐Yes Past _____
Urinary retention	☐No	☐Yes Have Now	☐Yes Past _____
Loss of touch or pain sensation	☐No	☐Yes Have Now	☐Yes Past _____
Double vision	☐No	☐Yes Have Now	☐Yes Past _____
Blindness	☐No	☐Yes Have Now	☐Yes Past _____
Deafness	☐No	☐Yes Have Now	☐Yes Past _____
Seizures	☐No	☐Yes Have Now	☐Yes Past _____
Amnesia	☐No	☐Yes Have Now	☐Yes Past _____
Fainting	☐No	☐Yes Have Now	☐Yes Past _____

Please list all of the operations and <u>medical hospitalizations</u> you have had.

Women:

Do you menstruate? Yes No

Are your periods Regular Irregular Heavy Medium Light

Menstrual Difficulties ĺNo Yes Have Now Yes Past _____

Number of Times Pregnant _____

Number of Children_____

Pain on intercourse Yes No

Premenstrually, do you have?

Worsening Moods Yes No

Mood Changes Yes No

Irritability Yes No

Decrease In interest Yes No

Decrease in energy Yes No

Change in sleep patterns Yes No

Marked increase in anxiety or tension Yes No

Difficulty concentrating Yes No

Increase or decrease in appetite Yes No

Physical symptoms such as: Yes No

Breast tenderness Yes No

Headaches Yes No

Joint or muscle pain Yes No

Men:

Prostate Trouble No Yes Have Now Yes Past _____

Difficulty urinating No Yes Have Now Yes Past _____

Sexual difficulties No Yes Have Now **Y**es Past _____

Recent stressful life events

(Circle any of the following that have occurred in the last two years)

Bad behavior of family member
Married
Engaged
Separated
Divorced
Serious argument
Breakup of important relationship
Child left home
Death of spouse, child or other significant other
Bad health of family member
Difficulties with family member
Personal injury, illness
Sexual difficulties
Difficulties at work or school
Retired or lost job
Changed residences
Legal difficulties, multiple traffic tickets
Owe money

In Last Month	Mild	Moderate	Severe	Problems Come and Go
Memory Problems				Yes No
Concentration Problems				Yes No

List who lives at home with you and their relation to you eg. **wife, mother, stepson.**

_____

_____

_____

_____

_____

_____

_____

Spirituality:

What religion were you raised in?

_____

What religion do you consider your self now?

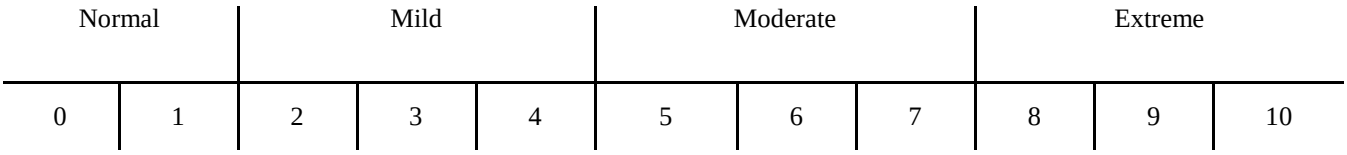
_____

Do you attend church or other services?

Yes No

How often? _____

How sensitive to criticism are you?



Where do you work? _____

Please list all the jobs you have had in the last five years and the reasons for the change.

_____

_____

_____

_____

_____

Place of birth: City _____ State_____

How many cities have you lived in in your life? _____

How far did you go in school? _____ If completed college what did you study _____

Circle those that apply:

Race: Caucasian African American Hispanic Asian Native American Other_____

Place where you live is: House Apartment Room Dormitory Hotel Other_____

Marital status: Never married Living cooperatively Married Separate Divorced/annulled Widow/ widower Other _____ If married How many times?_____

Have you ever had any legal involvement as a child or Adolescent Yes No

Have you had or have now any legal involvement Yes No

Have you been in the military? Yes No

Years in military _____ Branch _____

Rank _____ Discharge type _____

Anything else you think I should know about?

What psychiatric diagnosis or diagnosis do you think you might have?

What psychiatric diagnosis or diagnosis are you afraid you might have?

+0