

PLEASE NOTE: If you do not desire to answer any question, merely write, "Do not care to answer."

Today's Date: _____

1. General Information

Your Name: _____

Address: _____ ZIP _____

Telephone #: _____ - _____ - _____ Occupation: _____

Please Specify At Which Phone Number To Leave Messages: _____

Emergency Contact: _____

Reason For Consultation: _____

Referred By (e.g., doctor/other patient/self/website):

Your Age: _____ Height: _____ Weight: _____ Date of Birth: _____

Your Place of Birth: _____

With whom are you now living (List people): _____

Do you live in a house, hotel, room, apartment, etc.? _____

Are you: Single – Married – Separated – Divorced – Widowed - Living with Significant Other

3 PERSONAL DATA

Underline any of the following that applied during your childhood. (Give any details on back of page.)

- | | | | |
|---------------|-----------------------|------------------|-------------------|
| hyperactivity | learning difficulties | conduct problems | night terrors |
| sleep walking | stammering | fears | happy childhood |
| | | | unhappy childhood |

List all illness or health problems you have had at any time in your life. Be sure to include endocrine or glandular problems, such as thyroid problems.

Describe Illness or Health Problem(s)	Your Age at Time of Illness

List all Surgical Operations and Describe	Your Age at Time of Surgery

List any Accidents and Describe	Your Age at Time of Accident

When was the last time you felt well both physically and emotionally for a sustained period? _____

Games and interests during childhood: _____

Interests and hobbies during adolescence: _____

Any athletic accomplishments? _____

Present interests, hobbies, activities: _____

How is most of your free time occupied? _____

Age of beginning school: _____ Age of finishing school: _____ Last grade in school: _____

Relationship to schoolmates: _____

Scholastic abilities and disabilities: _____

Were you ever bullied or given a nickname? Give details: _____

Do you make friends easily? _____ Do you keep them? _____

Did you ever experience fear of leaving your mother to go to school or camp? Give details: _____

Did you ever experience nausea and/or vomiting before going to school? _____

4. OCCUPATIONAL DATA

Age when started working: _____

Jobs held (in chronological order) and reasons for change: _____

Does your present work satisfy you? _____ If not, in what ways are you dissatisfied? _____

What do you earn? _____ How much does it cost you to live? _____

5. SEX INFORMATION

Parental attitudes to sex (e.g., was there sex instruction or discussion in the home?): _____

5a. MENSTRUAL HISTORY

Age at first period: _____ Are periods regular? _____ Duration: _____

Date of last period: _____ Do periods affect your moods? _____

6. MARITAL/LONG-TERM RELATIONSHIP HISTORY

How long did you know your partner before engagement? _____

For how long were you engaged? _____ Partner's Age: _____

Partner's occupation: _____

Partner's personality (in your own words): _____

In what areas is there compatibility? _____

In what areas is there incompatibility? _____

Give details of any previous marriage (s) or long-term relationships and how and when they were terminated:

Year Previous Relationship Began	Year Ended	Divorce, Separation or Death of Partner
1.		
2.		
3.		

Please list all pregnancies you have had in chronological order and give complete information requested below. If more space is needed, continue on back of this page.

Year	Number of months pregnancy lasted	Describe any illnesses or complications during pregnancy of delivery	Outcome (CHECK ONE)
1.			<input type="checkbox"/> Miscarriage <input type="checkbox"/> Elective abortion <input type="checkbox"/> Living child
2.			<input type="checkbox"/> Miscarriage <input type="checkbox"/> Elective abortion <input type="checkbox"/> Living child
3.			<input type="checkbox"/> Miscarriage <input type="checkbox"/> Elective abortion <input type="checkbox"/> Living child
4.			<input type="checkbox"/> Miscarriage <input type="checkbox"/> Elective abortion <input type="checkbox"/> Living child
5.			<input type="checkbox"/> Miscarriage <input type="checkbox"/> Elective abortion <input type="checkbox"/> Living child

Please list in chronological order and describe all of your children.

Name	Age	Sex	Describe Any Problems
1.			
2.			
3.			
4.			
5.			
6.			

7. FAMILY DATA

(A) Father:

Name: _____ Age: _____

Occupation: _____ Health: _____

If deceased, cause of death: _____ Your age at time of death: _____

(B) Mother:

Name: _____ Age: _____

Occupation: _____ Health: _____

If deceased, cause of death: _____ Your age at time of death: _____

(C) Brothers: (If any are deceased, please give your age at time of death and cause of death.)

Name	Age	Marital Status	Occupation

(D) Sisters: (If any are deceased, please give your age at time of death and cause of death.)

Name	Age	Marital Status	Occupation

Relationship with brothers and sisters:

(a) Past: _____

(b) Present: _____

Give a description of your mother's personality and her attitude towards you:

(a) Past: _____

(b) Present: _____

Were you ever separated from one or both parents during your childhood or adolescence (other than vacations) for more than a month? Please describe fully and give your age at the time.

If you have a step-parent, give your age when parent remarried: _____

If you were not brought up entirely by your parents, who did bring you up, and between what years? _____

In what ways were you punished by parents as a child? _____

Give an impression of your home atmosphere (i.e., the home in which child grew up. Mention state of compatibility between parents and children):

Were you able to confide in parents? _____

Give an outline of your religious training: _____

Who are the most important people in your life? _____

Has any member of your family (parents, siblings, significant other, children, etc.) ever had a problem with alcoholism or problem drinking?

List Family Member	Describe Problem	Describe any treatment or hospitalization for this problem

Has any member of your family ever had any other neurological, mental or emotional problem (for example, epilepsy, depression, "nervous breakdown")?

List Family Member	Describe Problem	Describe any treatment or hospitalization for this problem

8.
 (A) Present use of alcohol and/or drugs - give details.

(B) Have you ever used alcohol and/or drugs more than you do now? If so, at what age, and extent of

maximum use: _____

9.

(A) Are you sensitive to tea, coffee or cigarettes? _____

(B) Are you now taking an oral contraceptive? _____

If yes, which one? _____

Have you taken oral contraceptives in the past? _____

When and for how long? _____ Which one? _____

Why did you discontinue this? _____

History of skin reaction or other unusual or adverse reaction to:

Penicillin or other antibiotic	No	Yes	_____
Morphine, Demerol, other pain meds	No	Yes	_____
Novocaine or other anesthetics	No	Yes	_____
Tetanus antitoxin or other serum	No	Yes	_____
Iodine, methylate or other	No	Yes	_____

Adverse/Unexpected reaction to other drugs (e.g., corticosteroids? Non-steroidal anti-inflammatory drugs, e.g. Motrin?

No Yes _____

Are you sensitive to small doses of prescribed medication (e.g., pain killers, opiates, antidepressants, anti-anxiety drugs)?

No Yes _____

Known laundry detergent allergy No Yes _____

Known food allergies No Yes _____

Pt. Name _____

Date _____

Instructions:

Attached is a list of problems and complaints that people have. Please read each item carefully and CIRCLE the number next to the phrase which best describes HOW MUCH that item has bothered or distressed you during the past week or so, including today. Circle only one number for each item and do not skip any items. If you change your mind erase your first circle.

HOW MUCH WERE YOU AFFECTED BY:

seldom often

		1	2	3	4	5
1.	Headaches.	1	2	3	4	5
2.	Nervousness or shakiness inside.	1	2	3	4	5
3.	Unwanted thoughts, words or ideas that won't leave your head.	1	2	3	4	5
4.	While sitting quietly, I have had uplifting sensations as if I were driving over a rolling road.	1	2	3	4	5
5.	Faintness or dizziness.	1	2	3	4	5
6.	Loss of sexual interest or pleasure.	1	2	3	4	5
7.	Feeling critical of others.	1	2	3	4	5
8.	I keep a diary or notebook about my feelings and thoughts.	1	2	3	4	5
9.	The idea that someone else can control your thoughts.	1	2	3	4	5
10.	Feeling critical of others.	1	2	3	4	5
11.	The idea that something is wrong with your mind.	1	2	3	4	5
12.	When I lose an argument, I spend a lot of time thinking about what I should have said.	1	2	3	4	5
13.	Feeling others are to blame for most of your troubles.	1	2	3	4	5
14.	Trouble remembering things.	1	2	3	4	5
15.	Worried about sloppiness or carelessness.	1	2	3	4	5
16.	I have been known to walk in my sleep.	1	2	3	4	5
17.	Feeling easily annoyed or irritated.	1	2	3	4	5

18.	Pains in heart or chest.	1	2	3	4	5
19.	Feeling afraid in open spaces or on the street.	1	2	3	4	5
20.	I often feel as if things are not real.	1	2	3	4	5
21.	Feeling low in energy or slowed down.	1	2	3	4	5
22.	Thoughts of ending your life.	1	2	3	4	5
23.	Hearing voices that other people do not hear.	1	2	3	4	5
24.	At least once in my life just, before falling down, I had the intense smell from childhood.	1	2	3	4	5
25.	Trembling.	1	2	3	4	5
26.	Feeling that most people cannot be trusted.	1	2	3	4	5
27.	Poor appetite.	1	2	3	4	5
28.	Once in a crowded area I suddenly could not recognize where I was.	1	2	3	4	5
29.	Crying easily.	1	2	3	4	5
30.	Feeling shy or uneasy with the opposite sex.	1	2	3	4	5
31.	Feeling of being trapped or caught.	1	2	3	4	5
32.	I have had a vision.	1	2	3	4	5
33.	Suddenly scared for no reason.	1	2	3	4	5
34.	Temper outbursts that you could not control.	1	2	3	4	5
35.	Feeling afraid to go out of the house alone.	1	2	3	4	5
36.	About once a year, I will awaken and not be able to move.	1	2	3	4	5
37.	Blaming yourself for things.	1	2	3	4	5
38.	Pains in lower back.	1	2	3	4	5
39.	Feeling blocked in getting things done.	1	2	3	4	5
40.	As a child I played with an imaginary friend.	1	2	3	4	5
41.	Feeling lonely.	1	2	3	4	5

42.	Feeling blue.	1	2	3	4	5
43.	Worrying too much about things.	1	2	3	4	5
44.	At least once in the last 10 years I have fallen asleep and then awakened the next morning in another room.	1	2	3	4	5
45.	Feeling no interest in things.	1	2	3	4	5
46.	Feeling fearful.	1	2	3	4	5
47.	Your feelings being easily hurt.	1	2	3	4	5
48.	People tell me I "blank out" sometimes when we are talking.	1	2	3	4	5
49.	Other people being aware of your private thoughts.	1	2	3	4	5
50.	Feeling others do not understand you or are unsympathetic.	1	2	3	4	5
51.	Feeling that people are unfriendly.	1	2	3	4	5
52.	Intense smells bother me more than most people.	1	2	3	4	5
53.	Having to do things very slowly.	1	2	3	4	5
54.	Heart pounding or racing.	1	2	3	4	5
55.	Nausea or upset stomach.	1	2	3	4	5
56.	When relaxed or just before falling asleep I sometimes feel pleasant vibrations moving through my whole body.	1	2	3	4	5
57.	Feeling inferior to others.	1	2	3	4	5
58.	Soreness of your muscles.	1	2	3	4	5
59.	Feeling that you are watched or talked about by others.	1	2	3	4	5
60.	Sometimes in the early morning hours between midnight and 4:00 am, my experiences are very meaningful.	1	2	3	4	5
61.	Trouble falling asleep.	1	2	3	4	5
62.	Having to check and double check what you do.	1	2	3	4	5
63.	Difficulty making decisions.	1	2	3	4	5
64.	I have heard an inner voice call my name.	1	2	3	4	5

65.	Feeling afraid to travel on buses, subways or trains.	1	2	3	4	5
66.	Trouble getting your breath.	1	2	3	4	5
67.	Hot or cold spells.	1	2	3	4	5
68.	After writing poetry or prose, I feel better.	1	2	3	4	5
69.	Having to avoid certain things, places or activities.	1	2	3	4	5
70.	Your mind going blank.	1	2	3	4	5
71.	Numbness or tingling in parts of your body.	1	2	3	4	5
72.	When I get upset or angry, my legs feel weak.	1	2	3	4	5
73.	A lump in your throat.	1	2	3	4	5
74.	Feeling hopeless about the future.	1	2	3	4	5
75.	Trouble concentrating.	1	2	3	4	5
76.	When I walk upstairs, I sometimes note a strange smell from nowhere.	1	2	3	4	5
77.	Feeling weak in parts of your body.	1	2	3	4	5
78.	Feeling tense or keyed up.	1	2	3	4	5
79.	Heavy feelings in your arms or legs.	1	2	3	4	5
80.	I use "hunches" more than simple learning to solve new problems.	1	2	3	4	5
81.	Thoughts of death or dying.	1	2	3	4	5
82.	Overeating.	1	2	3	4	5
83.	Feeling uneasy when people are watching or talking about you.	1	2	3	4	5
84.	At least once a month, I experience smells that do not have an obvious source.	1	2	3	4	5
85.	Having thoughts that are not your own.	1	2	3	4	5
86.	Having urges to beat, injure or harm someone.	1	2	3	4	5
87.	Awakening in the early morning.	1	2	3	4	5

88.	Once I start talking in an enjoyable setting, I have a hard time leaving.	1	2	3	4	5
89.	Having to repeat the same actions, such as touching, counting, washing.	1	2	3	4	5
90.	Sleep that is restless or disturbed.	1	2	3	4	5
91.	Having urges to break or smash things.	1	2	3	4	5
92.	Sometimes an event will occur that has special significance for me only.	1	2	3	4	5
93.	Having ideas or beliefs that others do not share.	1	2	3	4	5
94.	Feeling very self-conscious with others.	1	2	3	4	5
95.	Feeling uneasy in crowds, such as shopping or at a movie.	1	2	3	4	5
96.	If I breath quickly, I feel dizzy or odd.	1	2	3	4	5
97.	Feeling everything is an effort.	1	2	3	4	5
98.	Spells of terror or panic.	1	2	3	4	5
99.	Feeling uncomfortable about eating or drinking in public.	1	2	3	4	5
100.	I have had experiences when I felt as if I were somewhere else.	1	2	3	4	5
101.	Getting into frequent arguments.	1	2	3	4	5
102.	Feeling nervous when you are left alone.	1	2	3	4	5
103.	Others not giving you proper credit for your achievements.	1	2	3	4	5
104.	Feeling lonely even when you are with people.	1	2	3	4	5
105.	There have been times when I stared at an object and it appeared to become larger and larger.	1	2	3	4	5
106.	Feeling so restless you couldn't sit still.	1	2	3	4	5
107.	Feelings of worthlessness.	1	2	3	4	5
108.	Feeling that familiar things are strange or unreal.	1	2	3	4	5

109.	Two or three times in my life, there have been a few brief moments when I felt very close to a Universal Consciousness.	1	2	3	4	5
110.	Shouting or throwing things.	1	2	3	4	5
111.	Feeling afraid you will faint in public.	1	2	3	4	5
112.	Feeling that people will take advantage of you if you let them.	1	2	3	4	5
113.	I have dreams of floating or flying throught the air at least once a year.	1	2	3	4	5
114.	Having thoughts about sex that bother you a lot.	1	2	3	4	5
115.	The idea that you should be punished for your sins.	1	2	3	4	5
116.	Feeling pushed to get things done.	1	2	3	4	5
117.	When I have a tough decision to make a sign will be given and I will know what to do.	1	2	3	4	5
118.	The idea that something serious is wrong with your body.	1	2	3	4	5
119.	Never feeling close to another person.	1	2	3	4	5
120.	Feelings of guilt.	1	2	3	4	5
121.	The idea that something is wrong with your mind.	1	2	3	4	5

ANSWER BASED ON HOW YOU WERE WHEN YOU WERE A CHILD. THIS SECTION BE ANSWERED ONLY BY THE PATIENT.

WENDER UTAH RATING SCALE (WURS)

PATIENT'S INITIALS _____

PATIENT'S NUMBER _____

DATE _____

M.D.'S INITIALS _____

<u>AS A CHILD I WAS (OR HAD):</u>	Not at all or very slightly	Mildly	Moderately	Quite a Bit	Very Much
1. Active, restless, always on the go					
2. Afraid of things					
3. Concentration problems, easily distracted					
4. Anxious, worrying					
5. Nervous, fidgety					
6. Inattentive, daydreaming					
7. Hot or short tempered, low boiling point					
8. Shy, sensitive					
9. Temper outbursts, tantrums					
10. Trouble with stick-to-it-tiveness, not following through, failing to finish things started					
11. Stubborn, strong willed					
12. Sad or blue, depressed, unhappy					
13. Uncautious, dare-devillish, involved in pranks					
14. Not getting a kick out of things					
15. Disobedient with parents, rebellious, sassy					
16. Low opinion of myself					
17. Irritable					
18. Outgoing, friendly, enjoy company of people					
19. Sloppy, disorganized					
20. Moody, have ups and downs					
21. Feel angry					
22. Have friends, popular					
23. Well organized, tidy, neat					

	Very slightly	Mildly	Moderately	Quite a Bit	Very Much
24. Acting without thinking, impulsive					
25. Tend to be immature					
26. Feel guilty, regretful					
27. Lose control of myself					
28. Tend to be or act irrational					
29. Unpopular with other children, didn't keep friends for long, didn't get along with other children					
30. Poorly coordinated, did not participate in sports					
31. Afraid of losing control of self					
32. Well coordinated, picked first in games					
33. (For women only) Tomboyish					
34. Ran away from home					
35. Getting into fights					
36. Teased other children					
37. Leader, bossy					
38. Difficulty getting awake					
39. Follower, led around too much					
40. Trouble seeing things from someone else's point of view					
41. Trouble with authorities, trouble with school, visits to principal's office					
42. Trouble with the police, booked, convicted					
MEDICAL PROBLEMS AS A CHILD:					
43. Headaches					
44. Stomachaches					
45. Constipation					
46. Diarrhea					
47. Food allergies					
48. Other allergies					
49. Bedwetting					
AS A CHILD IN SCHOOL:					
50. Overall a good student, fast					

	Or very slightly	Mildly	Moderately	Quite a Bit	Very Much
51. Overall a poor student, slow learner					
52. Slow in learning to read					
53. Slow reader					
54. Trouble reversing letters					
55. Problems with spelling					
56. Trouble with mathematics or numbers					
57. Bad handwriting					
58. Though I could read pretty well, I never really enjoyed reading					
59. Did not achieve up to potential					
60. Repeated grades (which grades?)					
61. Suspended or expelled (which grades?)					