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PATIENT INFORMATION

Date: _____

Patient's Name: _____ SSN: _____ - _____ - _____ Sex: Male Female

Date of Birth: _____ Age: _____ Marital Status: Single Married Separated Divorced Widowed

Home Address: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____

Occupation: _____ Unemployed Student Pre-school child

Employer/School (if student): _____ Work/School Phone: (_____) _____

Employer/School Address: _____

E-mail Address: _____ Fax Phone: (_____) _____

Driver's License Number: _____ Emergency Contact: _____ (_____) _____

RESPONSIBLE PARTY and/or SPOUSE'S INFORMATION

Responsible Party: _____ SSN: _____ - _____ - _____ Date of Birth: _____

Home Address: _____

Home Phone: (_____) _____ Occupation: _____

Employer: _____ Work Phone: (_____) _____

Employer Address: _____ Driver's License No.: _____

Marital Status: Single Married Separated Divorced Widowed

Spouse's Name: _____ SSN: _____ - _____ - _____ Date of Birth: _____

Spouse's Employer: _____ Address: _____

INSURANCE BILLING: We do not bill insurance. We will provide patients with receipts that may be submitted to insurance carriers for reimbursement. Patients/Responsible Parties are responsible for all charges whether or not they are covered by your insurance.

PAYMENT POLICY: Payment for services is required at the time they are rendered. Payment may be made by cash, personal check or credit card (Discover, MasterCard or Visa). As patients are expected to maintain a zero balance, our office does not send patients statements on a regular basis. Accounts need to stay current in order to maintain ongoing treatment. Unpaid accounts over 60 days old are routinely reviewed for submission to our collection agency.

FEES CHARGED: The fees charged are based on the amount of time scheduled for dealing with patient issues. The minimum amount of time scheduled/charged is for a half session (20-30 minutes in length). If additional time beyond the scheduled time is taken to assist patients, there will be a charge for the amount of time used. In addition, patients are charged for time spent with a patient on the telephone, time taken to write duplicate prescriptions outside of scheduled appointments, and time taken to write reports or correspondence on patient's behalf.

APPOINTMENT CANCELLATION POLICY: Cancellations for scheduled appointments must be received 24 hours in advance during regular office hours (Monday through Thursday 8:30am to 5:00pm; Friday, 8:30am to Noon). **Un-kept appointments or late cancellations will be charged the appointment fee.** This fee can equal but will not exceed the fee for the time originally scheduled. Insurance companies do not pay for unkept appointment fees and the patient/responsible party is held fully accountable for this charge.

I have read and understand the above stated policies.

Signature of Responsible Party (required): _____

Name: _____

MEDICAL HISTORY

Current medical problems/medications: _____

Current supplements/vitamins/herbs: _____

Past medical problems/medications: _____

Other doctors/clinics seen regularly: _____

Any history of head trauma? (describe): _____

Ever any seizures or seizure like activity? _____

Prior hospitalizations (place, cause, date, outcome): _____

Prior abnormal lab tests, X-rays, EEG, etc: _____

Allergies/drug intolerances (describe): _____

Present Height _____ Present Weight _____

CURRENT LIFE STRESSES (include anything that is currently stressful for you, examples include relationships, job, school, finances, children) _____

Prenatal and birth events: Your parents' attitudes toward their pregnancy with you _____
Pregnancy complications (bleeding, excess vomiting, medication, infections, x-rays, smoking, alcohol/drug use, etc). _____

Any birth problems, trauma, forceps or complications? _____

Sleep behavior: sleepwalking, nightmares, recurrent dreams, current problems (getting up, going to bed) _____

School History: Last grade completed _____ Last school attended _____

Average grades received _____ Specific learning disabilities _____

Learning strengths _____

Any behavior problems in school? _____

What have teachers said about you? _____

Please bring school report cards and any state, national or special diagnostic testing that has been performed.

Employment History: (summarize jobs you've had, list most favorite and least favorite) _____

Any work-related problems? _____

What would your employers or supervisors say about you? _____

Name: _____

Military History? _____

Ever Any Legal Problems? _____

Sexual history: (answer only as much as you feel comfortable)

Age at the time of first sexual experience: _____ Number of sexual partners: _____

Any history of sexually transmitted disease? _____ History of abortion? _____

History of sexual abuse, molestation or rape? _____

Current sexual problems? _____

Alcohol and Drug History: (Please list age started and types of substances used through the years and any current usage. Also, describe how each of these substances made you feel; what benefit you got from them.). These include alcohol (hard liquor, beer, wine), marijuana or hash, prescription tranquilizers or sleeping pills, inhalants (glue, gasoline, cleaning fluids, etc.), cocaine or crack, amphetamines or crank or ice, steroids, opiates (heroin, codeine, morphine or other pain killers), barbiturates, hallucinating drugs (LSD, mescaline, mushrooms), PCP. _____

Ever experience withdrawal symptoms from alcohol or drugs? _____

Has anyone told you they thought you had a problem with drugs or alcohol? _____

Have you ever felt guilty about your drug or alcohol use? _____

Have you ever felt annoyed when someone talked to you about your drug or alcohol use? _____

Have you ever used drugs or alcohol first thing in the morning? _____

Caffeine use per day (caffeine is in coffee, tea, sodas, chocolate) _____

Nicotine use per day, past and present, (nicotine is in cigarettes, cigars, tobacco chew) _____

FAMILY HISTORY

Family Structure (who lives in your current household, please give relationship to each):

Current Marital or Relationship Satisfaction _____

Significant Developmental Events (include marriages, separations, divorces, deaths, traumatic events, losses, abuse, etc.) _____

History of Past Marriages _____

Name: _____

Natural Mother's History: age _____ outside work _____

School: highest grade completed _____

Learning problems _____ Behavior problems _____

Marriages _____

Medical Problems _____

Childhood atmosphere (family position, abuse, illnesses, etc) _____

Has mother ever sought psychiatric treatment? Yes ___ No ___ If yes, for what purpose? _____

Mother's alcohol/drug use history _____

Have any of your mother's blood relatives ever had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalizations? (specify) _____

Natural Father's History: age _____ outside work _____

School: highest grade completed _____

Learning problems _____ Behavior problems _____

Marriages _____

Medical Problems _____

Childhood atmosphere (family position, abuse, illnesses, etc) _____

Has father ever sought psychiatric treatment? Yes ___ No ___ If yes, for what purpose? _____

Father's alcohol/drug use history _____

Have any of your father's blood relatives ever had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalizations? (specify) _____

Siblings (names, ages, problems, strengths, relationship to patient) _____

Children (names, ages, problems, strengths) _____

Cultural/Ethnic Background _____

Describe your relationships with friends _____

Describe yourself _____

Describe your strengths _____

Name: _____

Adult General Symptom Checklist

Please rate yourself on each of the symptoms listed below using the following scale.

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

- ___ 1. depressed or sad mood
- ___ 2. decreased interest in things that are usually fun, including sex
- ___ 3. significant weight gain or loss, or marked appetite changes, increased or decreased
- ___ 4. recurrent thoughts of death or suicide
- ___ 5. sleep changes, lack of sleep or marked increase in sleep
- ___ 6. physically agitated or "slowed down"
- ___ 7. low energy or feelings of tiredness
- ___ 8. feelings of worthlessness, helplessness, hopelessness or guilt
- ___ 9. decreased concentration or memory
- ___ 10. periods of an elevated, high or irritable mood
- ___ 11. periods of a very high self esteem or grandiose thinking
- ___ 12. periods of decreased need for sleep without feeling tired
- ___ 13. more talkative than usual or pressure to keep talking
- ___ 14. racing thoughts or frequent jumping from one subject to another
- ___ 15. easily distracted by irrelevant things
- ___ 16. marked increase in activity level
- ___ 17. excessive involvement in pleasurable activities that have the potential for painful consequences (spending money, sexual indiscretions, gambling, foolish business ventures)
- ___ 18. panic attacks, which are periods of intense, unexpected fear or emotional discomfort (list number per month ___)
- ___ 19. periods of trouble breathing or feeling smothered
- ___ 20. periods of feeling dizzy, faint or unsteady on your feet
- ___ 21. periods of heart pounding or rapid heart rate
- ___ 22. periods of trembling or shaking
- ___ 23. periods of sweating
- ___ 24. periods of choking
- ___ 25. periods of nausea or abdominal upset
- ___ 26. feelings of a situation "not being real"
- ___ 27. numbness or tingling sensations
- ___ 28. hot or cold flashes
- ___ 29. periods of chest pain or discomfort
- ___ 30. fear of dying
- ___ 31. fear of going crazy or doing something uncontrolled
- ___ 32. avoiding everyday places for fear of having a panic attack or 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. persistent, excessive phobia (heights, closed spaces, specific animals, etc.) please list _____
- ___ 35. recurrent bothersome thoughts, ideas or images which you try to ignore
- ___ 36. trouble getting "stuck" on certain thoughts, or having the same thought over and over

Name: _____

- ___ 37. excessive or senseless worrying
- ___ 38. others complain that you worry too much or get "stuck" on the same thoughts
- ___ 39. compulsive behaviors that you must do or 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 you become very upset
- ___ 41. others complain that you do the same thing over and over to an excessive degree (such as cleaning or checking)
- ___ 42. recurrent and upsetting thoughts of a past traumatic event (molest, accident, fire, etc.) please list _____
- ___ 43. recurrent distressing dreams of a past upsetting event
- ___ 44. a sense of reliving a past upsetting event
- ___ 45. a sense of panic or fear to events that resemble an upsetting past event
- ___ 46. you spend effort avoiding thoughts or feelings associated with a past trauma
- ___ 47. persistent avoidance of activities/situations that cause remembrance of upsetting event
- ___ 48. inability to recall an important aspect of a past upsetting event
- ___ 49. marked decreased interest in important activities
- ___ 50. feeling detached or distant from others
- ___ 51. feeling numb or restricted in your feelings
- ___ 52. feeling that your future is shortened
- ___ 53. quick startle
- ___ 54. feels like you're always watching for bad things to happen
- ___ 55. marked physical response to events that remind you of a past upsetting event, i.e., sweating when getting in a car if you had been in a car accident
- ___ 56. marked irritability or anger outbursts
- ___ 57. unrealistic or excessive worry in at least a couple areas of your life
- ___ 58. trembling, twitching or feeling shaky
- ___ 59. muscle tension, aches or soreness
- ___ 60. feelings of restlessness
- ___ 61. easily fatigued
- ___ 63. heart pounding or racing
- ___ 64. sweating or cold clammy hands
- ___ 65. dry mouth
- ___ 66. dizziness or lightheadedness
- ___ 67. nausea, diarrhea or other abdominal distress
- ___ 68. frequent urination
- ___ 69. trouble swallowing or "lump in throat"
- ___ 70. feeling keyed up or on edge
- ___ 71. quick startle response or feeling jumpy
- ___ 72. difficult concentrating or "mind going blank"
- ___ 73. trouble falling or staying asleep
- ___ 74. irritability
- ___ 75. trouble sustaining attention or being easily distracted
- ___ 76. difficulty completing projects
- ___ 77. feeling overwhelmed of the tasks of everyday living
- ___ 78. trouble maintaining an organized work or living area
- ___ 79. inconsistent work performance
- ___ 80. lacks attention to detail
- ___ 81. makes decisions impulsively
- ___ 82. difficulty delaying what you want, having to have your needs met immediately
- ___ 83. restless, fidgety

Name: _____

- ___ 84. make comments to others without considering their impact
- ___ 85. impatient, easily frustrated
- ___ 86. frequent traffic violations or near accidents
- ___ 87. refusal to maintain body weight above a level most people consider healthy
- ___ 88. intense fear of gaining weight or becoming fat even though underweight
- ___ 89. feelings of being fat, even though you're underweight
- ___ 90. recurrent episodes of binge eating large amounts of food
- ___ 91. a feeling of lack of control over eating behavior
- ___ 92. engage in regular activities to purge binges, such as self-induced vomiting, laxatives, diuretics, strict dieting or strenuous exercise
- ___ 93. persistent over-concern with body shape and weight
- ___ 94. involuntary physical movements or motor tics (such as eye blinking, shoulder shrugging, head jerking or picking). How long have motor tics been present? _____ How often? _____ describe _____
- ___ 95. involuntary vocal sounds or verbal tics (such as coughing, puffing, blowing, whistling, swearing,.) How long have verbal tics been present? _____ How often? _____ Describe _____
- ___ 96. 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. periods of time where your thoughts or speech were disjointed or didn't make sense to you or others.
- ___ 100. social isolation or withdrawal
- ___ 101. severely impaired ability to function at home or at work
- ___ 102. peculiar behaviors
- ___ 103. lack of personal hygiene or grooming
- ___ 104. inappropriate mood for the situation (i.e., laughing at sad events)
- ___ 105. marked lack of initiative
- ___ 106. frequent feelings that someone or something is out to hurt you or discredit you
- ___ 107. periods of extreme irritability, physical or verbal aggression or rage with little provocation
- ___ 108. periods of confusion
- ___ 109. periods of spaciness or missing brief periods of time
- ___ 110. periods of fearfulness for no apparent reason
- ___ 111. periods of deja vu (the feeling that you've been or experienced something before even though you never have)
- ___ 112. periods of unusual visual (seeing) or auditory (hearing) sensations or illusions
- ___ 113. periods of forgetfulness or memory problems
- ___ 114. do you snore loudly (or do others complain about your snoring)
- ___ 115. have others said you stop breathing when you sleep
- ___ 116. do you feel fatigued or tired during the day
- ___ 117. do you often feel cold when others feel fine or they are warm
- ___ 118. do you often feel warm when others feel fine or they are cold
- ___ 119. do you have problems with brittle or dry hair
- ___ 120. do you have problems with dry skin
- ___ 121. do you have problems with sweating

Name: _____

Brief Learning Questionnaire

Reading

How well do you read? _____

Do you like to read? _____

When you read, do you make mistakes like skipping words or lines or reading the same line twice? _____

Do you find that you don't remember what you read, even though you've read all the words? _____

Writing

How is your handwriting? _____

How is your spelling, grammar, and punctuation? _____

Do you have trouble copying off the board? _____

Do you usually write in cursive or print? _____

Do you have trouble getting thoughts from your brain to the paper? _____

Math

Do you know your multiplication tables? _____

Do you switch numbers around _____

Do you sometimes forget what you're supposed to be doing in the middle of a problem? _____

Sequencing

When you speak do you have trouble getting everything in the right order (switch words or ideas around)? _____

Can you name the months of the year without problems? _____

Do you have trouble using the alphabet in order? _____

Do you have to start from the beginning of the alphabet each time? _____

Abstraction

Do you understand jokes when your friends tell them? _____

Do you sometimes get confused when people seem to say something, yet you find out they meant something else? _____

Organization

What does your notebook (room, desk, locker, book bag) look like? _____

Are your papers organized or a mess? _____

Do you have multiple piles everywhere? _____

Do you have trouble organizing your thoughts or the facts you're learning into a whole concept? _____

Do you have trouble planning your time? _____

Name: _____

Memory

Do you find that you can learn something at night and then forget what you learned the next day? _____

Do you sometimes forget what you're going to say right in the middle of saying it? _____

Language

When someone is speaking do you have trouble keeping up or understanding what is being said? _____

Do you misunderstand people and give the wrong answer? _____

Do you have problems finding the right words to use? _____

Name: _____

General Adult ADD Symptom Checklist

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. Other person is: _____

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

Past History

Other Self

- ___ ___ 1. History of ADD symptoms in childhood, such as distractibility, short attention span, impulsivity or restlessness. ADD doesn't start at age 30.
- ___ ___ 2. History of not living up to potential in school or work. (Report cards with comments such as "not living up to potential.")
- ___ ___ 3. History of frequent behavior problems in school (mostly for males).
- ___ ___ 4. History of bedwetting past 5 years old.
- ___ ___ 5. Family history of ADD, learning problems, mood disorders or substance abuse problems.

Short Attention Span/Distractibility

Other Self

- ___ ___ 6. Short attention span, unless very interested in something.
- ___ ___ 7. Easily distracted, tendency to drift away (although at times can be hyper focused).
- ___ ___ 8. Lacks attention to detail, due to distractibility.
- ___ ___ 9. Trouble listening carefully to directions.
- ___ ___ 10. Frequently misplaces things.
- ___ ___ 11. Skips around while reading, or goes to the end first, trouble staying on track.
- ___ ___ 12. Difficulty learning new games, because it is hard to stay on track during directions.
- ___ ___ 13. Easily distracted during sex, causing frequent breaks or turn-offs during lovemaking.
- ___ ___ 14. Poor listening skills.
- ___ ___ 15. Tendency to be easily bored (spaces out).

Restlessness

Other Self

- ___ ___ 16. Restlessness, constant motion, legs moving, fidgetiness.
- ___ ___ 17. Has to be moving in order to think.
- ___ ___ 18. Trouble sitting still, such as trouble sitting in one place for too long, sitting at a desk job for long periods, sitting through a movie.
- ___ ___ 19. An internal sense of anxiety or nervousness.

Impulsivity

Other Self

- ___ ___ 20. Impulsive, in words and/or actions (such as spending).
- ___ ___ 21. Say just what comes to mind without considering its impact (tactless).
- ___ ___ 22. Trouble going through established channels, trouble following proper procedure, an attitude of "read the directions when all else fails."
- ___ ___ 23. Impatient, low frustration tolerance.
- ___ ___ 24. A prisoner of the moment.
- ___ ___ 25. Frequent traffic violations
- ___ ___ 26. Frequent, impulsive job changes.
- ___ ___ 27. Tendency to embarrass others.
- ___ ___ 28. Lying or stealing on impulse.

Name: _____

Poor Organization

Other Self

- ___ ___29. Poor organization and planning, trouble maintaining an organized work/living area.
___ ___30. Chronically late or chronically in a hurry.
___ ___31. Often have piles of stuff.
___ ___32. Easily overwhelmed by tasks of daily living.
___ ___33. Poor financial management (late bills, checkbook a mess, spending unnecessary money on late fees).
___ ___34. Some adults with ADD are very successful, but often only if they are surrounded with people who organize them.

Problems Getting Started and Following Through

Other Self

- ___ ___35. Chronic procrastination or trouble getting started.
___ ___36. Starting projects and not finishing; poor follow-through.
___ ___37. Enthusiastic beginnings but poor endings.
___ ___38. Spends excessive time at work because of inefficiencies.
___ ___39. Inconsistent work performance.

Negative Internal Feelings

Other Self

- ___ ___40. Chronic sense of underachievement; feeling you should be much further along in your life than you are.
___ ___41. Chronic problems with self-esteem.
___ ___42. Sense of impending doom.
___ ___43. Mood swings.
___ ___44. Negativity.
___ ___45. Frequent feeling of demoralization or that things won't work out for you.

Relational Difficulties

Other Self

- ___ ___46. Trouble sustaining friendships or intimate relationships, promiscuity.
___ ___47. Trouble with intimacy.
___ ___48. Tendency to be immature.
___ ___49. Self-centered; immature interests.
___ ___50. Failure to see others' needs or activities as important.
___ ___51. Lack of talking in a relationship.
___ ___52. Verbally abusive to others.
___ ___53. Proneness to hysterical outburst.
___ ___54. Avoids group activities.
___ ___55. Trouble with authority.

Short Fuse

Other Self

- ___ ___56. Quick responses to slights that are real or imagined
___ ___57. Rage outbursts; short fuse.

Search for High Stimulation

Other Self

- ___ ___58. Frequent search for high stimulation (bungee jumping, gambling, racetrack, high stress jobs such as ER doctor, doing many things at once, etc.)
___ ___59. Tendency to seek conflict, be argumentative or to start disagreements for the fun of it.

Name: _____

Tendency to Get Stuck (Thoughts or Behaviors)

Other Self

- ___ ___ 60. Tendency to worry needlessly and endlessly.
___ ___ 61. Tendency toward addictions (food, alcohol, drugs, work).

Switches things around

Other Self

- ___ ___ 62. Switches around numbers, letters or words.
___ ___ 63. Turns words around in conversations.

Writing/Fine Motor Coordination Difficulties

Other Self

- ___ ___ 64. Poor writing skills (hard to get information from brain to pen).
___ ___ 65. Poor handwriting, often prints.
___ ___ 66. Coordination difficulties.

The Harder I Try, The Worse It Gets

Other Self

- ___ ___ 67. Performance becomes worse under pressure.
___ ___ 68. Test anxiety, or during tests your mind tends to go blank.
___ ___ 69. The harder you try, the worse it gets.
___ ___ 70. Work or schoolwork deteriorates under pressure.
___ ___ 71. Tendency to turn off or become stuck when asked questions in social situations.
___ ___ 72. Falls asleep or becomes tired while reading.

Sleep/Wake Difficulties

Other Self

- ___ ___ 73. Difficulties falling asleep, may be due to too many thoughts at night.
___ ___ 74. Difficulty coming awake (may need coffee or other activity before feeling fully awake).

Low Energy

Other Self

- ___ ___ 75. Periods of low energy, especially early in the morning and in the afternoon.
___ ___ 76. Frequently feeling tired.

Sensitive to Noise or Touch

Other Self

- ___ ___ 77. Startles easily.
___ ___ 78. Sensitive to touch, clothes, noise and light.

Total Score: _____ (Add up all the "3's" and "4's" only. Count each "3" or "4" as 1 point)

Name: _____

Criteria for AD/HD

Attention-Deficit/Hyperactivity Disorder

(DSM-IV)

Check each of the following symptoms that has persisted for at least six months.

Inattention

- ___ 1. Often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities.
- ___ 2. Often has difficulty sustaining attention in tasks or play activities.
- ___ 3. Often does not seem to listen when spoken to directly.
- ___ 4. Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions).
- ___ 5. Often has difficulty organizing tasks or activities.
- ___ 6. Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as school work or homework).
- ___ 7. Often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools).
- ___ 8. Is often easily distracted by extraneous stimuli
- ___ 9. Is often forgetful in daily activities.

Hyperactivity

- ___ 1. Often fidgets with hands or feet, or squirms in seat.
- ___ 2. Often leaves seat in classroom, or in other situations in which remaining seated is expected.
- ___ 3. Often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness).
- ___ 4. Often has difficulty playing or engaging in leisure activities quietly.
- ___ 5. Is often "on the go" or often acts as if "driven by a motor."
- ___ 6. Often talks excessively.

Impulsivity

- ___ 7. Often blurts out answers before questions have been completed.
- ___ 8. Often has difficulty waiting for his/her turn.
- ___ 9. Often interrupts or intrudes on others (e.g., butts into conversations or games).

Name: _____

Hallmarks of ADD

Check each of the following symptoms that apply.

Without Hyperactivity

- ___ 1. Difficulty with sustained attention or erratic attention span
- ___ 2. Easily distracted by extraneous stimuli
- ___ 3. Excessive daydreaming
- ___ 4. Disorganized
- ___ 5. Responds impulsively or without thinking
- ___ 6. Problems completing things
- ___ 7. Doesn't seem to listen
- ___ 8. Shifts from one uncompleted activity to another
- ___ 9. Often complains of being bored
- ___ 10. Often appears to be apathetic or unmotivated
- ___ 11. Frequently sluggish or slow moving
- ___ 12. Frequently spacey or internally preoccupied

Over-focused Subtype

- ___ 1. Difficulty with sustained attention or erratic attention span
- ___ 2. Easily distracted by extraneous stimuli
- ___ 3. Excessive or senseless worrying
- ___ 4. Disorganized or super-organized
- ___ 5. Oppositional, argumentative
- ___ 6. Strong tendency to get locked into negative thoughts, having the same thought over and over.
- ___ 7. Tendency toward compulsive behavior
- ___ 8. Intense dislike for change
- ___ 9. Tendency to hold grudges
- ___ 10. Trouble shifting attention from subject to subject
- ___ 11. Difficulties seeing options in situations
- ___ 12. Tendency to hold on to own opinion and not listen to others
- ___ 13. Tendency to get locked into a course of action, whether or not it is good for the person
- ___ 14. Needing to have things done a certain way or you become very upset
- ___ 15. Others complain that you worry too much
- ___ 16. A strong tendency to hold grudges, to hold on to hurts from the past

Depressive Subtype

- ___ 1. Difficulty with sustained attention or erratic attention span
- ___ 2. Easily distracted by extraneous stimuli
- ___ 3. Moodiness
- ___ 4. Negativity
- ___ 5. Low energy
- ___ 6. Irritability
- ___ 7. Social isolation
- ___ 8. Hopelessness, helplessness, excessive guilt
- ___ 9. Disorganization
- ___ 10. Lowered interest in things that are usually considered fun
- ___ 11. Sleep changes (too much or too little)
- ___ 12. Forgetfulness
- ___ 13. Chronic low self-esteem

Explosive Subtype

- ___ 1. Difficulty with sustained attention or erratic attention span
- ___ 2. Easily distracted by extraneous stimuli
- ___ 3. Impulse control problems
- ___ 4. Short fuse or periods of extreme irritability
- ___ 5. Periods of rages with little provocation
- ___ 6. Often misinterprets comments as negative when they are not
- ___ 7. Irritability builds, then explodes, then recedes, often tired after a rage
- ___ 8. Periods of spaciness or confusion
- ___ 9. Periods of panic and/or fear for no specific reason
- ___ 10. Visual changes, such as seeing shadows or objects changing shape
- ___ 11. Frequent periods of deja vu (feelings of being somewhere before even though you never have)
- ___ 12. Sensitivity of mild paranoia
- ___ 13. History of a head injury or family history of violence or explosiveness
- ___ 14. Dark thoughts, may involve suicidal or homicidal thoughts
- ___ 15. Periods of forgetfulness or memory problems

Name: _____

Adult Depression Inventory

The following are groups of statements. Please read each group of statements carefully. Then select the one statement in each group that best describes the way you have been feeling **the past week, including today**. Circle the number beside the statement you selected. If several statements in the group seem to apply equally well, circle each one. **Be sure to read all the statements in each group before making your choice.**

1. 0 I do not feel sad.
1 I feel sad.
2 I am sad all the time and I can't snap out of it.
3 I am so sad or unhappy that I can't stand it.
2. 0 I am not particularly discouraged about the future.
1 I feel discouraged about the future.
2 I feel I have nothing to look forward to.
3 I feel the future is hopeless and things cannot improve.
3. 0 I do not feel like a failure.
1 I feel I have failed more than the average person.
2 As I look back on my life, all I can see are a lot of failures.
3 I feel I am a complete failure as a person.
4. 0 I get as much satisfaction out of things as I used to.
1 I don't enjoy things the way I used to.
2 I don't get satisfaction out of anything anymore.
3 I am dissatisfied or bored with everything.
5. 0 I don't feel particularly guilty.
1 I feel guilty a good part of the time.
2 I feel quite guilty most of the time.
3 I feel guilty all of the time.
6. 0 I don't feel I am being punished.
1 I feel I may be punished.
2 I expect to be punished.
3 I feel I am being punished.
7. 0 I don't feel disappointed in myself.
1 I am disappointed in myself.
2 I am disgusted with myself.
3 I hate myself.
8. 0 I don't feel I am any worse than anybody else.
1 I am critical of myself for my weaknesses or mistakes.
2 I blame myself all the time for my faults.
3 I blame myself for everything bad that happens.
9. 0 I don't have any thoughts of killing myself.
1 I have thoughts of killing myself, but I would not carry them out.
2 I would like to kill myself.
3 I would kill myself if I had the chance.
10. 0 I don't cry any more than usual.
1 I cry more now than in the past.
2 I cry all the time now.
3 I used to be able to cry, but now I can't cry even though I want to.
11. 0 I am no more irritated now than I ever was.
1 I get annoyed or irritated more easily now than in the past.
2 I feel irritated all the time now.
3 I don't get irritated at all by the things that used to irritate me.
12. 0 I have not lost interest in other people.
1 I am less interested in other people than I used to be.
2 I have lost most of my interest in other people.
3 I have lost all my interest in other people.
13. 0 I make decisions as well as I ever could.
1 I put off making decision more than I used to.
2 I have greater difficulty in making decision than before.
3 I can't make decisions anymore.
14. 0 I don't feel I look any worse than I used to.
1 I am worried that I am looking old or unattractive.
2 I feel that there are permanent changes in my appearance that make me feel unattractive
3 I believe that I look ugly.
15. 0 I can work as well as before.
1 It takes extra effort to get started at doing something.
2 I have to push myself very hard to do anything.
3 I can't do any work at all.
16. 0 I can sleep as well as usual.
1 I get tired more easily than I used to.
2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
3 I wake up several hours earlier than I used to and cannot get back to sleep.
17. 0 I don't get more tired than usual.
1 I get tired more easily than I used to.
2 I get tired from doing almost anything.
3 I am too tired to do anything.

Name: _____

Adult Depression Inventory (cont.)

18. 0 My appetite is no worse than usual.
1 My appetite is not as good as it used to be.
2 My appetite is much worse now.
3 I have no appetite at all anymore.
19. 0 I haven't lost much weight, if any, lately.
1 I have lost more than 5 pounds.
2 I have lost more than 10 pounds.
3 I have lost more than 15 pounds
4 I am purposely trying to lose weight by eating less.
Yes _____ No _____
20. 0 I am no more worried about my health than usual.
1 I am worried about physical problems such as aches and pains, or upset stomach or constipation.
2 I am very worried about physical problems and it's hard to think of much else.
3 I am so worried about my physical problems that I cannot think about anything else.
21. 0 I have not noticed any recent changes in my interest in sex.
1 I am less interested in sex than I used to be.
2 I am much less interested in sex now.
3 I have lost interest in sex completely.

Name: _____

Medical Review of Systems

Please place a check mark in the boxes that apply. Write any specific information next to the item for clarification.

<p>General</p> <ul style="list-style-type: none"><input type="checkbox"/> Poor appetite<input type="checkbox"/> Abnormal sensitivity to cold<input type="checkbox"/> Cold sweats during the day<input type="checkbox"/> Decreased sexual interest<input type="checkbox"/> Tired or worn out<input type="checkbox"/> Hot or cold spells<input type="checkbox"/> Abnormal sensitivity to hear<input type="checkbox"/> Increased appetite<input type="checkbox"/> Excessive sleeping<input type="checkbox"/> Lowered resistance to infection<input type="checkbox"/> Flu-like or vague sick feeling<input type="checkbox"/> Sweating excessively at night<input type="checkbox"/> Being overweight<input type="checkbox"/> Excessive daytime sweating<input type="checkbox"/> Urinating excessively<input type="checkbox"/> Excessive thirst<input type="checkbox"/> Recent weight gain<input type="checkbox"/> Recent weight loss<input type="checkbox"/> Other _____	<p>Respiratory</p> <ul style="list-style-type: none"><input type="checkbox"/> Asthma<input type="checkbox"/> Cough<input type="checkbox"/> Shortness of breath<input type="checkbox"/> Coughing up blood<input type="checkbox"/> Rapid breathing<input type="checkbox"/> Coughing up sputum<input type="checkbox"/> Repeated nose or chest colds<input type="checkbox"/> Wheezing<input type="checkbox"/> Other _____	<p>Head, Eye, Ear, Nose & Throat, cont.</p> <p><i>Nose</i></p> <ul style="list-style-type: none"><input type="checkbox"/> Disturbances in smell<input type="checkbox"/> Nosebleeds<input type="checkbox"/> Nose stuffiness<input type="checkbox"/> Nose itchiness<input type="checkbox"/> Runny nose<input type="checkbox"/> Sneezing<input type="checkbox"/> Other _____
<p>Neurological</p> <ul style="list-style-type: none"><input type="checkbox"/> Pacing due to muscle restlessness<input type="checkbox"/> Decreased movement<input type="checkbox"/> Forgotten periods of time<input type="checkbox"/> Emotion causes brief paralysis<input type="checkbox"/> Disorientation<input type="checkbox"/> Dizziness<input type="checkbox"/> Drowsiness<input type="checkbox"/> Muscle spasms or tremors<input type="checkbox"/> Excessive clumsiness<input type="checkbox"/> Impaired ability to remember<input type="checkbox"/> Muscle stiffness<input type="checkbox"/> "Tics"<input type="checkbox"/> Nightmares<input type="checkbox"/> Numbness<input type="checkbox"/> Paralysis<input type="checkbox"/> Tingling of "burning" feeling<input type="checkbox"/> Convulsions/fits<input type="checkbox"/> Slurred speech<input type="checkbox"/> Speech Problem<input type="checkbox"/> Fainting<input type="checkbox"/> Shaking<input type="checkbox"/> Spinning feeling<input type="checkbox"/> Weakness (localized)<input type="checkbox"/> Weakness (generalized)<input type="checkbox"/> Other _____	<p>Head, Eye, Ear, Nose & Throat</p> <p><i>Head</i></p> <ul style="list-style-type: none"><input type="checkbox"/> Facial pain<input type="checkbox"/> Headache<input type="checkbox"/> Head injury<input type="checkbox"/> Neck pain<input type="checkbox"/> Neck stiffness<input type="checkbox"/> Neck swelling<input type="checkbox"/> Pain behind the ear<input type="checkbox"/> Pain from jaw movement<input type="checkbox"/> Pain in temple<input type="checkbox"/> Scalp itching<input type="checkbox"/> Other _____ <p><i>Eye</i></p> <ul style="list-style-type: none"><input type="checkbox"/> Blindness<input type="checkbox"/> Blurred vision<input type="checkbox"/> Bloodshot or red eye<input type="checkbox"/> Double vision<input type="checkbox"/> Feels something in eye<input type="checkbox"/> Eye pain<input type="checkbox"/> Farsightedness<input type="checkbox"/> Increased tearing<input type="checkbox"/> Itching of eyes<input type="checkbox"/> Loss of vision from the side<input type="checkbox"/> Nearsightedness<input type="checkbox"/> Night blindness<input type="checkbox"/> Overly sensitive to light<input type="checkbox"/> Sees spots before eyes<input type="checkbox"/> Other _____ <p><i>Ear</i></p> <ul style="list-style-type: none"><input type="checkbox"/> Hearing loss in both ears<input type="checkbox"/> Ear discharge<input type="checkbox"/> Ear pain<input type="checkbox"/> Feeling of fullness in ear<input type="checkbox"/> Ear itching<input type="checkbox"/> Ear ringing<input type="checkbox"/> Hearing loss in one ear<input type="checkbox"/> Other _____	<p><i>Mouth</i></p> <ul style="list-style-type: none"><input type="checkbox"/> Dental (tooth or gum) problems<input type="checkbox"/> Dry mouth<input type="checkbox"/> Hoarseness<input type="checkbox"/> Too much saliva in mouth<input type="checkbox"/> Painful throat muscle spasms<input type="checkbox"/> Frequent sore throat<input type="checkbox"/> Sore tongue<input type="checkbox"/> Taste alteration<input type="checkbox"/> Tickling feeling in throat<input type="checkbox"/> Other _____ <p>Chest and Cardiovascular</p> <ul style="list-style-type: none"><input type="checkbox"/> Ankle swelling<input type="checkbox"/> Rapid/irregular pulse<input type="checkbox"/> Breast swelling<input type="checkbox"/> Breast mass<input type="checkbox"/> Breast tenderness<input type="checkbox"/> Chest pain<input type="checkbox"/> High blood pressure<input type="checkbox"/> Low blood pressure<input type="checkbox"/> Nipple leaking milk<input type="checkbox"/> Nipple bleeding<input type="checkbox"/> Nipple discharge<input type="checkbox"/> Breastbone tenderness<input type="checkbox"/> Other _____ <p>Musculoskeletal</p> <ul style="list-style-type: none"><input type="checkbox"/> Back pain<input type="checkbox"/> Back stiffness<input type="checkbox"/> Bone pain<input type="checkbox"/> Buttocks to ankle pain<input type="checkbox"/> "Heavy" legs<input type="checkbox"/> Calf pain on exercise<input type="checkbox"/> Joint pain<input type="checkbox"/> Joint stiffness<input type="checkbox"/> Leg pain<input type="checkbox"/> Muscle cramps<input type="checkbox"/> Muscle pain<input type="checkbox"/> Repeated bone fractures<input type="checkbox"/> Other _____

