# REQUIRED PATIENT INFORMATION

**Please print legibly** (circle answers or fill in blanks).

**Patient:** _____
First Middle Initial Last

Address: _____

City, State, Zip: _____

Home: (____)_____ Work: (____)_____

Cell Phone: (_____) _____

Best # to leave a confidential voicemail: Home Work Cell

Email Address_____

Patient Occupation: _____

Name of Employer: _____

Date of Birth: _____ Age: _____

Sex: M F Social Security #: _____

Marital Status:
Single Married Separated Widowed Divorced x ___

Education Level: _____ # of years_____

Dominant Hand: Right / Left / Ambidextrous

**Reason for Appointment**: _____

**Today's Date:** _____

**Emergency Contact:** _____
First Last

Relation: Parent Guardian Spouse Other: _____

Home: (____)_____ Cell: (____)_____

**Emergency Contact #2:** _____
(In case of minor, both parents must be listed.)

Relation: Parent Guardian Spouse Other: _____

Home: (____)_____ Cell: (____)_____

**For Minors: Name(s) of Custodial Parent(s)/Guardian(s):**
_____

**Address to send Statements:** _____

_____

_____

**Pharmacy (required):**_____

Address:_____

City, State, Zip: _____

Phone: (____)_____ Fax: (____)_____

**Referred By**: _____

---

1) **PCP Name:** _____

Clinic Name: _____

Street: _____

City, State, Zip: _____

Office: (____)_____ Fax: (____)_____

2)_____

Clinic Name: _____

Street: _____

City, State, Zip: _____

Office: (____)_____ Fax: (____)_____

3) **Therapist Name** (if applicable) _____

Clinic Name: _____

Street: _____

City, State, Zip: _____

Office: (____)_____ Fax: (____)_____

4) **Attorney** (if applicable) _____

Firm Name: _____

Street: _____

City, State, Zip: _____

Office: (____)_____ Fax: (____)_____

**INTAKE EVALUATION** (Attach additional sheets if needed)

Name: _____ Age: _____ Date: _____
Name would you like to go by: _____
Others present: _____
Marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Single ☐ In a Relationship
How long have you been with your partner/married? _____ Do you have any children? ☐ Yes ☐ No
If yes, how many & what are their ages? _____
Current living situation (relationship of person(s) with whom patient resides)? _____
_____

Are you interested in natural approaches to your treatment? ☐ Yes ☐ No

Allergies to medication:
_____ ☐ Allergy ☐ Adverse Reaction Please Describe: _____
_____ ☐ Allergy ☐ Adverse Reaction Please Describe: _____
_____ ☐ Allergy ☐ Adverse Reaction Please Describe: _____

**Reason for this appointment:**

What is your goal in scheduling an appointment with us today? _____
_____
_____
_____
_____

Please list the symptoms that you suffer with: _____
_____
_____
_____
_____

How long have you had these symptoms? _____
_____

Do these symptoms seem to come and go regularly, as in a cycle? ☐ Yes ☐ No If yes, please describe: _____
_____

**Current medications:** (IMPORTANT: Please list any prescription & non-prescription medications, vitamins, supplements or herbs; include name, dose & how often taken)_____
_____
_____
_____
_____
_____
_____
_____
_____

Who has been prescribing your meds? _____

Name: _____ Date: _____

**Medical History:**
Do you have any of the following medical conditions? (check all that apply, use the space provided next to each condition to elaborate if needed)

☐ High/Low blood pressure _____
☐ High cholesterol _____
☐ Heart disease _____
☐ Cancer _____
☐ Diabetes _____
☐ Liver problems _____
☐ Kidney problems _____
☐ Respiratory problems _____
☐ Asthma _____
☐ Nervous system disorder _____
☐ Seizures _____
☐ Gastrointestinal problems _____
☐ Blood disorder _____
☐ Thyroid disorder _____
☐ Other glandular disorder _____
☐ Sleep disorder _____
☐ Headaches/Migraines _____
☐ Pain disorder _____
☐ Plastic Surgery _____
☐ Other (please be specific) _____

When was your most recent physical? _____

Did you or your doctor have any concerns about your health? ☐ Yes ☐ No If yes, please describe: _____
_____
_____

Did you have any blood work done (i.e., thyroid testing)? ☐ Yes ☐ No
If yes, was anything abnormal? _____

Check any significant family medical illness or history:

☐ High/Low blood pressure
☐ High cholesterol
☐ Heart disease
☐ Kidney problems
☐ Respiratory problems
☐ Glucose intolerance and/or diabetes
☐ Asthma
☐ Nervous system disorder
☐ Seizures
☐ Gastrointestinal problems
☐ Blood disorder
☐ Thyroid disorder
☐ Other glandular disorder
☐ Sleep disorder
☐ Headaches/Migraines
☐ Pain disorder
☐ Other _____
_____

Do you currently, or have you in the past, experienced:
Depression? ☐ Yes ☐ No
Anxiety? ☐ Yes ☐ No
Panic attacks? ☐ Yes ☐ No
If yes, please describe when you experienced any of these: _____
_____

If you have depression and anxiety, which affects you more? _____

Have you had one or more severely stressful events that have affected your well-being? ☐ Yes ☐ No
If yes, please describe, including how long you have felt stressed: _____
_____
_____

Has your ability to handle stress and pressure decreased? ☐ Yes ☐ No
Do you experience constant stress in your life or work? ☐ Yes ☐ No
Are any of your relationships at work and/or home unhappy? ☐ Yes ☐ No
Do you feel overwhelmed and have little control over your life? ☐ Yes ☐ No

Name: _____ Date: _____

Do most events feel like a chore? ☐ Yes ☐ No

If you answered yes to any of the questions above, please describe: _____

_____

_____

_____

Have you experienced any traumas or Post-Traumatic Stress Disorder (PTSD)? ☐ Yes ☐ No

If yes, please describe: _____

_____

_____

_____

Do you have feelings of hopelessness or despair? ☐ Yes ☐ No

If yes, please help us understand why: _____

_____

_____

Do you exercise regularly? ☐ Yes ☐ No

Please answer the following questions, has there ever been a period of time when you were not your usual self and...

| | | |
|---|---|---|
| ...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 in trouble? | ☐ Yes | ☐ No |
| ...you were so irritable that you shouted at people or started fights or arguments? | ☐ Yes | ☐ No |
| ...you were much more self-confident than usual? | ☐ Yes | ☐ No |
| ...you got much less sleep than usual and found you didn't really miss it? | ☐ Yes | ☐ No |
| ...you were much more talkative or spoke faster than usual? | ☐ Yes | ☐ No |
| ...thoughts raced through your head or you couldn't slow your mind down? | ☐ Yes | ☐ No |
| ...you were so easily distracted by things around you that you had trouble concentrating or staying on track? | ☐ Yes | ☐ No |
| ...you had much more energy than usual? | ☐ Yes | ☐ No |
| ...you were much more active or did many more things than usual? | ☐ Yes | ☐ No |
| ...you were much more social or outgoing than usual; for example, you telephoned friends in the middle of the night? | ☐ Yes | ☐ No |
| ...you were much more interested in sex than usual? | ☐ Yes | ☐ No |
| ...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky? | ☐ Yes | ☐ No |
| ...spending money got you or your family into trouble? | ☐ Yes | ☐ No |

Total number of questions answered "Yes": _____

If you checked “Yes” to more than one of the questions above:

Have several of these ever happened during the same period of time? ☐ Yes ☐ No

How much of a problem did any of these cause you, like being unable to work; having family, money or legal troubles; getting into arguments or fights?

☐ No Problem ☐ Moderate Problem ☐ Minor Problem ☐ Serious Problem

| | | |
|---|---|---|
| Have any blood relatives had manic-depression or bipolar disorder? | ☐ Yes | ☐ No |
| Has a health professional ever told you that you have manic-depression or bipolar disorder? | ☐ Yes | ☐ No |
| Do you suffer from anorexia, bulimia or any other eating disorder? | ☐ Yes | ☐ No |

If yes, please describe: _____

_____

How is your appetite? _____

_____

_____

Name: _____ Date: _____

Have you had any recent changes in weight? ☐ Yes ☐ No If yes, please describe: _____
_____

How are you functioning sexually? Are any of your medications causing sexual side effects? _____
_____
_____

Are there other medical symptoms we should know about (e.g. forgetfulness, weight changes, dry, coarse skin/hair, change in bowel habits etc)? _____
_____
_____

**Support System:**
Do you feel that you have a support system? ☐ Family ☐ Friends ☐ Coworkers ☐ Other: _____

**Sleep Habits:**
Do you have any trouble falling asleep? ☐ Yes ☐ No If yes, what prevents you from falling asleep? _____
_____

How is the quality of your sleep (e.g., light, deep, etc.)? _____

Do you snore? ☐ Yes ☐ No ☐ Don't know

Have you been told that you stop breathing or gasp for breath when asleep? ☐ Yes ☐ No ☐ Don't know

Do you wake up in the middle of the night? ☐ Yes ☐ No
If so, how often and are you able to fall back to sleep? _____

Do you feel rested in the morning? ☐ Yes ☐ No ☐ Sometimes

How long have you suffered with sleep problems? _____

Have you ever had a sleep study? ☐ Yes ☐ No
If yes, when and what were the results? _____
_____
_____

If you have a problem with sleepiness or fatigue, please rate the following questions based on how likely you are to doze off or fall asleep in the following situations, in contrast to just feeling tired. Even if you haven't done some activities recently, think about how they would have affected you. Use this scale to choose the most appropriate number for each situation: 0= would never doze, 1= slight chance of dozing, 2= moderate chance of dozing, 3= high chance of dozing

| **Situation:** | **Chance of Dozing:** | | | |
|---|---|---|---|---|
| Sitting and reading | 0 | 1 | 2 | 3 |
| Watching television | 0 | 1 | 2 | 3 |
| Sitting inactive in a public place (i.e., a theater or meeting) | 0 | 1 | 2 | 3 |
| As a passenger in a car for an hour without a break | 0 | 1 | 2 | 3 |
| Lying down to rest in the afternoon | 0 | 1 | 2 | 3 |
| Sitting and talking to someone | 0 | 1 | 2 | 3 |
| Sitting quietly after lunch (when you've had no alcohol) | 0 | 1 | 2 | 3 |
| In a car, while stopped in traffic | 0 | 1 | 2 | 3 |
| **Add all of your circled numbers together to get a total score:** | | | | |

Name: _____ Date: _____

**Substance Use:**

Do you use alcohol? ☐ Yes ☐ No

If so, how many drinks do you have a night, and how many nights per week do you drink? _____

_____

When you drink do you drink to get buzzed, drunk, or black-out? _____

_____

Do you use nicotine? ☐ Yes ☐ No

If so, how much/often? _____

_____

Do you use any recreational drugs? ☐ Yes ☐ No

If so, which ones and how often? _____

_____

Do you have a history of drug use? ☐ Yes ☐ No

Does your use of any of these substances play a part in the reason for your appointment today? ☐ Yes ☐ No

If yes, please explain: _____

_____

Do family or friends disagree with this? ☐ Yes ☐ No

Have you ever been treated for substance abuse in the past? ☐ Yes ☐ No

If so, when and what type of treatment did you receive? _____

_____

_____

_____

Do any genetic relatives have a history of problems with alcohol or substance abuse? ☐ Yes ☐ No

If yes, which relative(s)? _____

**Psychiatric History:**

Have you had any past psychiatric treatment or psychotherapy? ☐ Yes ☐ No

If yes, please list the names of the psychiatrists or therapists you've seen, why you were you seen, when and for how long you were treated. _____

_____

_____

_____

_____

Have you had any hospitalizations for a psychiatric condition? ☐ Yes ☐ No

If yes, please explain: _____

_____

_____

Where and when were you hospitalized? _____

_____

_____

Name: _____ Date: _____

Are you currently in psychotherapy/counseling? ☐ Yes ☐ No
If yes, who is your therapist and how long have you seen him/her? _____
_____

If no, do you think psychotherapy would be of benefit? ☐ Yes ☐ No
Do you feel that your current or past psychiatric care/psychotherapy has been helpful to you? ☐ Yes ☐ No ☐ N/A
Why or why not? _____
_____
_____

Is there any family genetic psychiatric history? ☐ Yes ☐ No
If yes, please be specific (who has what problem? on mother's or father's side?). If no formal diagnoses were made, what is your "gut" feeling about your family genetic psychiatric history? _____
_____
_____

Are any relatives on medications? _____
Which medications? _____
Were they helpful? _____

Do you have any current thoughts of harming yourself or anyone else (thoughts, plans, attempts, cutting, passive thoughts of wishing you weren't here, etc.)? ☐ Yes ☐ No
If yes, please describe: _____
_____
_____
_____

Do you have a suicide or homicide plan? ☐ Yes ☐ No
If yes, please describe: _____
_____
_____
_____

Has there been any past history of suicidal attempts, cutting, or self-mutilation? ☐ Yes ☐ No
If yes, please explain: _____
_____
_____
_____

**Head Injuries:**
Have you ever had any head injury, sports injury to the head, falls, concussions or car accidents? ☐ Yes ☐ No (If no, skip to next section)
If yes, describe where on the head the injury occurred and at what age: _____
_____
_____

Was there any loss of consciousness or amnesia? ☐ Yes ☐ No ☐ Don't know

Has there been any change in mood or memory since the head trauma occurred? ☐ Yes ☐ No
If yes, please describe: _____
_____

Name: _____ Date: _____

Were you hospitalized for the head injury? ☐ Yes ☐ No
If yes, please describe: _____
_____

Was any type of scan performed (CAT scan, MRI, EEG, etc.)? ☐ Yes ☐ No ☐ Don't know
If yes, what did it show? _____

**Pain:**
Do you have any problems with pain? ☐ Yes ☐ No (If no, skip to next section)
If yes, describe your pain: _____
_____
_____

What is your average daily pain level, using the pain scale from 1 to 10, 10 being excruciating pain: _____
How long have you been suffering with this level of pain? _____
Are you being treated for this problem? ☐ Yes ☐ No
If yes, by whom? _____

**Female Patients:**
Do you have regular periods? ☐ Yes ☐ No ☐ N/A
If no, please describe: _____
_____
_____

Are you taking contraceptives? ☐ Yes ☐ No ☐ N/A
If so, did you notice a change in your mood when you started or stopped birth control? ☐ Yes ☐ No
If yes, please describe: _____
_____
_____

Have you noticed any perimenopausal/ menopausal symptoms (i.e., hair falling out, dry eyes, irregular periods, irritability, vaginal dryness, etc.)? ☐ Yes ☐ No ☐ N/A
If yes, have you consulted a doctor about this? ☐ Yes ☐ No
Did the doctor do any additional tests other than blood work, or how did the doctor treat your condition? _____
_____
_____

Do you have any PMS symptoms? ☐ Yes ☐ No
If yes, please describe, including how many days of your cycle the symptoms last: _____
_____
_____

**Childhood/Cultural History:**
Describe your childhood, including whether or not your parents divorced and if so, how old you were, any siblings and their ages, any trauma, physical, emotional or sexual abuse, and birth history. _____
_____
_____
_____
_____
_____
_____

Name: _____ Date: _____

Are there any cultural or spiritual factors that you would like to tell us about? _____
_____
_____
_____

**Legal History:**

Have you ever had any legal problems including jail, prison, lawsuits, bankruptcy, etc.? ☐ Yes ☐ No

If yes, please explain: _____
_____
_____

Are you presently on diversion or probation? ☐ Yes ☐ No

If yes, what are the requirements of your diversion or probation?_____
_____
_____

Have you ever served in the military? ☐ Yes ☐ No

If yes, what branch of the military? _____

What type of discharge did you receive? _____

# **INVENTORY OF DEPRESSIVE SYMPTOMOLOGY** (Self-Report) (IDS-SR)

Name: _____ Date: _____

Instructions: Please circle the one response to each item that best describes you for the past seven days.

1. Falling Asleep:
   - 0 I never take longer than 30 minutes to fall asleep.
   - 1 I take at least 30 minutes to fall asleep, less than half the time.
   - 2 I take at least 30 minutes to fall asleep, more than half the time.
   - 3 I take more than 60 minutes to fall asleep, more than half the time.

2. Sleep During the Night:
   - 0 I do not wake up at night.
   - 1 I have a restless, light sleep with a few brief awakenings each night.
   - 2 I wake up at least once a night, but I go back to sleep easily.
   - 3 I awaken more than once a night and stay awake for 20 minutes or more, more than half the time

3. Waking up Too Early:
   - 0 Most of the time, I awaken no more than 30 minutes before I need to get up.
   - 1 More than half the time, I awaken more than 30 minutes before I need to get up.
   - 2 I almost always awaken at least one hour or so before I need to, but I go back to sleep eventually.
   - 3 I awaken at least one hour before I need to, and can't go back to sleep.

4. Sleeping Too Much:
   - 0 I sleep no longer than 7-8 hours/night, without napping during the day.
   - 1 I sleep no longer than 10 hours in a 24-hour period including naps.
   - 2 I sleep no longer than 12 hours in a 24-hour period including naps.
   - 3 I sleep longer than 12 hours in a 24-hour period including naps.

5. Feeling Sad:
   - 0 I do not feel sad.
   - 1 I feel sad less than half the time.
   - 2 I feel sad more than half the time.
   - 3 I feel sad nearly all of the time.

6. Feeling Irritable:
   - 0 I do not feel irritable.
   - 1 I feel irritable less than half the time.
   - 2 I feel irritable more than half the time.
   - 3 I feel extremely irritable nearly all of the time.

7. Feeling Anxious or Tense:
   - 0 I do not feel anxious or tense.
   - 1 I feel anxious (tense) less than half the time.
   - 2 I feel anxious (tense) more than half the time.
   - 3 I feel extremely anxious (tense) nearly all of the time.

8. Response of Your Mood to Good or Desired Events:
   - 0 My mood brightens to a normal level which lasts for several hours when good events occur.
   - 1 My mood brightens but I do not feel like my normal self when good events occur.
   - 2 My mood brightens only somewhat to a rather limited range of desired events.
   - 3 My mood does not brighten at all, even when very good or desired events occur in my life.

Name: _____ Date: _____

9. Mood in Relation to the Time of Day:
   - 0 There is no regular relationship between my mood and the time of day.
   - 1 My mood often relates to the time of day because of environmental events (e.g., being alone, working).
   - 2 In general, my mood is more related to the time of day than to environmental events.
   - 3 My mood is clearly and predictably better or worse at a particular time each day.

   9A. Is your mood typically worse in the: ☐ Morning, ☐ Afternoon, or ☐ Night?

   9B. Is your mood variation attributed to the environment? ☐ Yes ☐ No

10. The Quality of Your Mood:
   - 0 The mood (internal feelings) that I experience is very much a normal mood.
   - 1 My mood is sad, but this sadness is pretty much like the sad mood I would feel if someone close to me died or left.
   - 2 My mood is sad, but this sadness has a rather different quality to it than the sadness I would feel if someone close to me died or left.
   - 3 My mood is sad, but this sadness is different from the type of sadness associated with grief or loss.

***PLEASE COMPLETE EITHER 11 OR 12 (NOT BOTH).***

11. Decreased Appetite:
   - 0 There is no change in my usual appetite.
   - 1 I eat somewhat less often or lesser amounts of food than usual.
   - 2 I eat much less than usual and only with personal effort.
   - 3 I rarely eat within a 24-hour period, and only with extreme personal effort or when others persuade me to eat.

12. Increased Appetite:
   - 0 There is no change from my usual appetite.
   - 1 I feel a need to eat more frequently than usual.
   - 2 I regularly eat more often and/or greater amounts of food than usual.
   - 3 I feel driven to overeat both at mealtime and between meals.

***PLEASE COMPLETE EITHER 13 OR 14 (NOT BOTH)***

13. Decreased Weight (Within the Last Two Weeks):
   - 0 I have not had a change in my weight.
   - 1 I feel as if I've had a slight weight loss.
   - 2 I have lost between 2-4 pounds.
   - 3 I have lost 5 pounds or more.

14. Increased Weight (Within the Last Two Weeks):
   - 0 I have not had a change in my weight.
   - 1 I feel as if I've had a slight weight gain.
   - 2 I have gained 2-4 pounds.
   - 3 I have gained 5 pounds or more.

15. Concentration/Decision Making:
   - 0 There is no change in my usual capacity to concentrate or make decisions.
   - 1 I occasionally feel indecisive or find that my attention wanders.
   - 2 Most of the time, I struggle to focus my attention or to make decisions.
   - 3 I cannot concentrate well enough to read or cannot make even minor decisions.

Name: _____ Date: _____

16. View of Myself:
    0 I see myself as equally worthwhile and deserving as other people.
    1 I am more self-blaming than usual.
    2 I largely believe that I cause problems for others.
    3 I think almost constantly about major and minor defects in myself.

17. View of My Future:
    0 I have an optimistic view of my future.
    1 I am occasionally pessimistic about my future, but for the most part I believe things will get better.
    2 I'm pretty certain that my immediate future (1-2 months) does not hold much promise of good things for me.
    3 I see no hope of anything good happening to me anytime in the future.

18. Thoughts of Death or Suicide:
    0 I do not think of suicide or death.
    1 I feel that life is empty or wonder if it's worth living.
    2 I think of suicide or death several times a week for several minutes.
    3 I think of suicide or death several times a day in some detail, or I have made specific plans for suicide or have actually tried to take my life.

19. General Interest:
    0 There is no change from usual in how interested I am in other people or activities.
    1 I notice that I am less interested in people or activities.
    2 I find I have interest in only one or two of my formerly pursued activities.
    3 I have virtually no interest in formerly pursued activities.

20. Energy Level:
    0 There is no change in my usual level of energy.
    1 I get tired more easily than usual.
    2 I have to make a big effort to start or finish my usual daily activities (for example, shopping, homework, cooking or going to work).
    3 I really cannot carry out most of my usual daily activities because I just don't have the energy.

21. Capacity for Pleasure or Enjoyment (excluding sex):
    0 I enjoy pleasurable activities just as much as usual.
    1 I do not feel my usual sense of enjoyment from pleasurable activities.
    2 I rarely get a feeling of pleasure from any activity.
    3 I am unable to get any pleasure or enjoyment from anything.

22. Interest in Sex (Please Rate Interest, not Activity):
    0 I'm just as interested in sex as usual.
    1 My interest in sex is somewhat less than usual or I do not get the same pleasure from sex as I used to.
    2 I have little desire for or rarely derive pleasure from sex.
    3 I have absolutely no interest in or derive no pleasure from sex.

23. Feeling Slowed Down:
    0 I think, speak, and move at my usual rate of speed.
    1 I find that my thinking is slowed down or my voice sounds dull or flat.
    2 It takes me several seconds to respond to most questions and I'm sure my thinking is slowed.
    3 I am often unable to respond to questions without extreme effort.

Name: _____ Date: _____

24. Feeling Restless:
    0 I do not feel restless.
    1 I'm often fidgety, wring my hands, or need to shift how I am sitting.
    2 I have impulses to move about and am quite restless.
    3 At times, I am unable to stay seated and need to pace around.

25. Aches and Pains:
    0 I don't have any feeling of heaviness in my arms or legs and don't have any aches or pains.
    1 Sometimes I get headaches or pains in my stomach, back or joints but these pains are only sometime present and they don't stop me from doing what I need to do.
    2 I have these sorts of pains most of the time.
    3 These pains are so bad they force me to stop what I am doing.

26. Other Bodily Symptoms:
    0 I don't have any of these symptoms: heart pounding fast, blurred vision, sweating, hot and cold flashes, chest pain, heart turning over in my chest, ringing in my ears, or shaking.
    1 I have some of these symptoms but they are mild and are present only sometimes.
    2 I have several of these symptoms and they bother me quite a bit.
    3 I have several of these symptoms and when they occur I have to stop doing whatever I am doing.

27. Panic/Phobic Symptoms:
    0 I have no spells of panic or specific fears (phobia, such as animals or heights).
    1 I have mild panic episodes or fears that do not usually change my behavior or stop me from functioning.
    2 I have significant panic episodes or fears that force me to change my behavior but do not stop me from functioning.
    3 I have panic episodes at least once a week or severe fears that stop me from carrying on my daily activities.

28. Constipation/Diarrhea:
    0 There is no change in my usual bowel habits.
    1 I have intermittent constipation or diarrhea which is mild.
    2 I have diarrhea or constipation most of the time but it does not interfere with my day-to-day activities.
    3 I have constipation or diarrhea for which I take medicine or which interferes with my day-to-day activities.

29. Interpersonal Sensitivity:
    0 I have not felt easily rejected, slighted, criticized or hurt by others at all.
    1 I have occasionally felt rejected, slighted, criticized or hurt by others.
    2 I have often felt rejected, slighted, criticized or hurt by others, but these feelings have had only slight effects on my relationships or work.
    3 I have often felt rejected, slighted, criticized or hurt by others and these feelings have impaired my relationships and work.

30. Leaden Paralysis/Physical Energy:
    0 I have not experience the physical sensation of feeling weighted down and without physical energy.
    1 I have occasionally experienced periods of feeling physically weighted down and without physical energy, but without a negative effect on work, school, or activity level.
    2 I feel physically weighted down (without physical energy) more than half the time.
    3 I feel physically weighted down (without physical energy) most of the time, several hours per day, several days per week.

**PSYCHIATRIC SYMPTOMS**
**(For Adult Patients Only)**

Name: _____ Date: _____

Below is a list of common psychiatric symptoms. Please carefully read each item in the list. Indicate how much you have been bothered by that symptom during the past month, including today, by circling the number in the corresponding space in the column next to each symptom.

| | Not At All | Mildly - but it didn't bother me much. | Moderately - it wasn't pleasant at times | Severely – it bothered me a lot |
|---|---|---|---|---|
| Numbness or tingling | 0 | 1 | 2 | 3 |
| Feeling hot | 0 | 1 | 2 | 3 |
| Wobbliness in legs | 0 | 1 | 2 | 3 |
| Unable to relax | 0 | 1 | 2 | 3 |
| Fear of worst happening | 0 | 1 | 2 | 3 |
| Dizzy or lightheaded | 0 | 1 | 2 | 3 |
| Heart pounding/racing | 0 | 1 | 2 | 3 |
| Unsteady | 0 | 1 | 2 | 3 |
| Terrified or afraid | 0 | 1 | 2 | 3 |
| Nervous | 0 | 1 | 2 | 3 |
| Feeling of choking | 0 | 1 | 2 | 3 |
| Hands trembling | 0 | 1 | 2 | 3 |
| Shaky / unsteady | 0 | 1 | 2 | 3 |
| Fear of losing control | 0 | 1 | 2 | 3 |
| Difficulty in breathing | 0 | 1 | 2 | 3 |
| Fear of dying | 0 | 1 | 2 | 3 |
| Scared | 0 | 1 | 2 | 3 |
| Indigestion | 0 | 1 | 2 | 3 |
| Faint / lightheaded | 0 | 1 | 2 | 3 |
| Face flushed | 0 | 1 | 2 | 3 |
| Hot/cold sweats | 0 | 1 | 2 | 3 |
| **Column Sum** | | | | |

***Scoring -*** Sum each column. Then sum the column totals to achieve a grand score.

Write that score here _____

**QUALITY OF LIFE ENJOYMENT AND SATISFACTION QUESTIONNAIRE - SHORT FORM (Q-LES-Q-SF)**

Patient Name: _____ Date: _____

**Instructions:** Please place a check mark in the box that best describes your satisfaction **during the past few weeks**. Answer questions 1 through 16, using the N/A for those which do not apply.

| **Taking everything into consideration, during the past few weeks,** | **OVERALL LEVEL OF SATISFACTION** | | | | | |
|---|---|---|---|---|---|---|
| | Very Poor | Poor | Fair | Good | Very Good | |
| **How satisfied have you been with your...** | 1 | 2 | 3 | 4 | 5 | N/A |
| 1) …physical health? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 2) …mood? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 3) …work? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 4) …household activities? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 5) …social relationships? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 6) …family relationships? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 7) …leisure time activities? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 8) …ability to function in daily life? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 9) …sexual drive, interest and/or performance? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 10) …economic status? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 11) …living/housing situation? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 12) …ability to get around physically without feeling dizzy or unsteady or falling? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 13) …your vision in terms of ability to do work or hobbies? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 14) …overall sense of well being? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 15) …medication? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| 16) How would you rate your overall life satisfaction and contentment during the past few weeks? | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

| **OFFICE USE ONLY** | |
|---|---|
| **Total Raw Score from Questions 1-14 (0-70):** | + + + + = |
| **Total number of questions Unanswered in Questions 1-14 above (valid test must be 0-4):** | |
| **PERCENTAGE:** | % |