Puget Sound Behavioral Medicine
2553 76TH AVE SE
MERCER ISLAND, WA 98040
PHONE/FAX 206/275-0702

ADULT QUESTIONNAIRE

To help us to fully evaluate your concerns, please fill out the following intake form and questionnaire to the best of your ability. We realize that there is a lot of information requested and you may not remember or have access to all of it, but please be as thorough as possible.

PATIENT IDENTIFICATION:

Name _____ Age _____ Sex _____

Birth Date _____ Marital Status _____

Address _____

City _____ State ____ Zip _____ - _____

Home Phone ___ / ___ - _____ Work Phone ___ / ___ - _____ Cell Phone ___ / ___ - _____

Who do you currently live with? _____

REFERRAL SOURCE:

Name _____ Phone ___ / ___ - _____ Fax___ / ___ - _____

Address _____

Do we have permission to release information to the referral source when it is appropriate?

Yes___ No___

CHOICE OF DOCTOR: (mark an "X" by your choice of doctor)

___ Dr. Ted Mandelkorn

___ Dr. Janice Woolley

___ No preference

MAIN PURPOSE FOR THE CONSULTATION (please give a summary of the main problem)

_____

_____

_____

_____

_____

_____

_____

WHY DID YOU SEEK THE EVALUATION AT THIS TIME? (What are your goals for this visit?)

_____

_____

_____

_____

PLEASE LIST YOUR HISTORY OF PRIOR ATTEMPTS TO CORRECT YOUR PROBLEM/ PRIOR PSYCHIATRIC HISTORY.

_____

_____

_____

_____

_____

MEDICAL HISTORY:

Current medical problems and/or medications:

_____

_____

Current Supplements/vitamins/herbs:

_____

_____

Past medical problems/medications:

_____

_____

Other doctors/clinics seen regularly:

_____

_____

Any history of head trauma? (describe)

_____

_____

Any history of seizures or seizure-like activity?

_____

_____

Prior hospitalizations:

_____

_____

Prior abnormal lab tests/values?

_____

_____

Allergies/ drug intolerance?

_____

_____

CURRENT LIFE STRESSES: (include anything that is currently stressful for you, such as relationships, job, school, finances, children)

_____

_____

_____

YOUR PRENATAL AND BIRTH EVENTS: (Pregnancy complication, birth trauma, bleeding, medication, smoking, alcohol/drugs)

_____

_____

SLEEP BEHAVIOR: (trouble getting to sleep, trouble staying asleep, excessive snoring, sleepwalking, nightmares, recurrent dreams, excessive daytime sleepiness)

_____

_____

SCHOOL HISTORY: Last grade completed ___ Last school attended _____

Average grades received_____ Specific learning disabilities_____

Any behavior problems in school?

_____

_____

What have teachers said about your learning and behavior in school? (Please send copies of any report cards, state testing, psychological tests that have been done in the past.)

_____

_____

_____

EMPLOYMENT HISTORY: (summarize the jobs you have held; most favorite, least favorite)

_____

_____

_____

Any work-related problems?

_____

_____

What have your employers and supervisors said about your performance?

_____

_____

MILITARY HISTORY: ___

LEGAL PROBLEMS/DIFFICULTY WITH THE LAW:

_____

_____

ALCOHOL AND DRUG HISTORY: Please list the age you started, 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. This question includes 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, hallucinogenic drugs (LSD, mescaline, mushrooms), PCP:

_____

_____

_____

_____

_____

Did you ever experience withdrawal symptoms from alcohol or drugs? _____

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

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

Have you felt annoyed when someone talked to you about your use of drugs/alcohol? _____

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

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

Nicotine use per day, past and present (cigarettes, cigars, chewing tobacco) _____

SEXUAL HISTORY: (answer if comfortable)

Age at time of first sexual experience _____ Number of sex partners _____

History of sexually transmitted diseases _____ History of abortion_____

History of sexual molestation, abuse or rape _____

_____ _____

Current sexual problems?

_____

_____

_____

FAMILY HISTORY:

Family structure (Who lives in your current household? Please give relationship to each)

_____

_____

_____

Current marital or relationship satisfaction:

_____

_____

Significant events (include marriages, separations, divorces, deaths, traumatic events)

_____

_____

History of past marriages:

_____

_____

NATURAL MOTHER'S HISTORY: Age_____ Outside work _____

School-highest grade completed _____ Learning Problems_____

Behavioral Problems _____ Marriages _____

Medical Problems _____

Has mother or any maternal relatives had any learning problems or psychiatric problems including alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalization, physical or sexual abuse? If yes, please describe

_____

_____

_____

NATURAL FATHER'S HISTORY: Age_____ Outside work _____

School-highest grade completed _____ Learning Problems_____

Behavioral Problems _____ Marriages _____

Medical Problems _____

Has father or any paternal relatives had any learning problems or psychiatric problems including alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalization, physical or sexual abuse? If yes, please describe

_____

_____

_____

SIBLINGS: (names, ages, problems, strengths, relations with patient)

_____

_____

_____

CHILDREN: (names, ages, problems, strengths, relations with patient)

_____

_____

_____

CULTURAL/ETHNIC BACKGROUND:

_____

_____

DESCRIBE YOUR RELATIONSHIP WITH FRIENDS:

_____

DESCRIBE YOURSELF/ YOUR STRENGTHS:

_____

_____

_____

GENERAL SYMPTOM CHECKLIST

Please rate yourself on each of the symptoms below using the following scale. If possible, to give us the most complete picture, have another person who knows you well (spouse, lover, or parent) rate you as well. List other person_____

0	1	2	3	4	N/A
Never	Rarely	Occasionally	Frequently	Very Frequently	Not applicable

Other	Self		
____	____	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
____	____	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 feel pressure to keep talking
____	____	14.	Racing thoughts; frequent jumps from one subject to another
____	____	15.	Easily distracted by irrelevant things
____	____	16.	Marked increases in activity level
____	____	17.	Excessive involvement in pleasurable activities which have the potential for painful consequences (spending money, sexual indiscretions, gambling, foolish business ventures)
____	____	18.	Panic attacks, which are period 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.	Feeling of a situation “not being real”
____	____	27.	Numbness or tingling sensation
____	____	28.	Hot or cold flashes
____	____	29.	Periods of chest pain or discomfort
____	____	30.	Fear of dying

0	1	2	3	4	N/A
Never	Rarely	Occasionally	Frequently	Very Frequently	Not applicable

Other	Self	
____	____	31. Fear of going crazy or doing something uncontrolled
____	____	32. Avoiding everyday places for fear of having a panic attack, or need 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 phobias (heights, closed spaces, specific animals, etc.) Please list_____
____	____	35. Recurrent, bothersome thoughts, ideas, images, which you try to ignore
____	____	36. Trouble getting "stuck" on certain thoughts, or having the same thought over and over
____	____	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 over and over or else you feel anxious (i.e., handwashing, checking locks),
or		compulsive spelling or counting
____	____	40. Needing to have things done a certain way or you become upset
____	____	41. Others complain that you do the same thing over and over to an excessive degree (cleaning, checking)
____	____	42. Recurrent and upsetting thoughts of a past traumatic event (molestation, accident, fire, etc)
____	____	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 which cause remembrance of upsetting events
____	____	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. Feel like you are 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 long after you have been in an accident)

0 Never	1 Rarely	2 Occasionally	3 Frequently	4 Very Frequently	N/A Not applicable

Other	Self	
____	____	56. Marked irritability or angry outbursts
____	____	57. Unrealistic or excessive worry in at least a couple of areas in your life.
____	____	58. Trembling, twitching or feeling shaky
____	____	59. Muscle tension, aches or soreness
____	____	60. Easily fatigued
____	____	61. Feelings of restlessness
____	____	62. Shortness of breath or feeling smothered
____	____	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. Hot or cold flashes
____	____	69. Frequent urination
____	____	70. Trouble swallowing or “lump in throat”
____	____	71. Feeling keyed up or on edge
____	____	72. Quick startle response or jumpy feeling
____	____	73. Difficulty concentrating or “mind going blank”
____	____	74. Trouble falling asleep or staying asleep
____	____	75. Irritability
____	____	76. Trouble sustaining attention or being easily distracted
____	____	77. Difficulty completing projects
____	____	78. Feeling overwhelmed with the tasks of everyday life
____	____	79. Trouble maintaining an organized work area or living area
____	____	80. Inconsistent work performance
____	____	81. Lack of attention to detail
____	____	82. Make decisions impulsively
____	____	83. Difficulty delaying what you want, having to have your needs met immediately
____	____	84. Restless or fidgety
____	____	85. Make comments to others without considering their impact
____	____	86. Impatient, easily frustrated
____	____	87. Frequent traffic violations or frequent near accidents
____	____	88. Refusal to maintain body weight above a level most people consider healthy
____	____	89. Intense fear of gaining weight or becoming fat even though underweight
____	____	90. Feelings of being fat, even though you are underweight

0	1	2	3	4	N/A
Never	Rarely	Occasionally	Frequently	Very Frequently	Not applicable

Other	Self	
____	____	91. Recurrent episodes of binge eating
____	____	92. Feeling of lack of control over eating behavior
____	____	93. Persistent overconcern with body shape or weight
____	____	94. Engage in regular activities to end binges such as self-induced vomiting, laxatives, diuretics, dieting or strenuous exercise
____	____	95. Involuntary movements (tics) or vocal tics
____	____	96. Delusional or bizarre thoughts (that 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 did not make sense to you or others
____	____	100. Social isolation or withdrawal
____	____	101. Severely impaired ability to function at home or work or socially
____	____	102. Peculiar behaviors
____	____	103. Lack of personal hygiene or grooming
____	____	104. Marked lack of initiative
____	____	105. Inappropriate mood for the situation (laughing at sad events)
____	____	106. Frequent feeling that someone or something is out to hurt you or discredit you
____	____	107. Do others complain that you snore loudly?
____	____	108. Have others said you stop breathing when you sleep?
____	____	109. Do you feel fatigued or tired during the day?
____	____	110. Do you often feel cold when others feel fine or warm?
____	____	111. Do you often feel warm when others feel fine or cool?
____	____	112. Do you have problems with brittle or dry hair?
____	____	113. Do you have problems with dry skin?
____	____	114. Do you have problems with sweating?

LEARNING DISABILITY SCREENING QUESTIONNAIRE

0	1	2	3	4	N/A
Never	Rarely	Occasionally	Frequently	Very Frequently	Not applicable

READING

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

WRITING

____ 1. I have "messy" handwriting
____ 2. My work tends to be messy
____ 3. I prefer to print rather than write in cursive
____ 4. My letters run into each other, or there is no space between words
____ 5. I have trouble staying within the lines
____ 6. I have trouble with grammar and/or punctuation
____ 7. I am a poor speller
____ 8. I have trouble copying off the board or from a page in a book
____ 9. I have trouble getting thoughts from my brain to the paper
____ 10. I can tell a story but cannot write it

BODY AWARENESS/SPATIAL RELATIONSHIPS

____ 1. I have trouble knowing my left from my right
____ 2. I have trouble keeping things within columns or coloring within lines
____ 3. I tend to be clumsy, uncoordinated
____ 4. I have difficulty with eye/hand coordination
____ 5. I have difficulty with concepts, such as up, down, over or under
____ 6. I tend to bump into things when walking

ORAL EXPRESSIVE LANGUAGE

____ 1. I have difficulty expressing myself in words
____ 2. I have trouble finding the right words to say in conversations
____ 3. I have trouble getting to the point in a conversation, talking around the subject

RECEPTIVE LANGUAGE

____ 1. I have trouble keeping up or understanding what is be said in conversations
____ 2. I tend to misunderstand people and give the wrong answer in conversations
____ 3. I have trouble understanding directions people give me
____ 4. I have trouble telling the direction sound is coming from
____ 5. I have trouble filtering out background noise

LEARNING DISABILITY SCREENING QUESTIONNAIRE

0	1	2	3	4	N/A
Never	Rarely	Occasionally	Frequently	Very Frequently	Not applicable

MATH

____ 1. I am poor at math skills for my age (add, subtract, multiple, divide)
____ 2. I make careless mistakes in math
____ 3. I tend to switch numbers around
____ 4. I have trouble with word problems

SEQUENCING

____ 1. I have trouble getting everything in the right order when I speak
____ 2. I have trouble telling time
____ 3. I have trouble saying the alphabet in order
____ 4. I have trouble saying the months of the year in order

ABSTRACTION

____ 1. I have trouble understanding jokes people tell me
____ 2. I tend to take things too literally

ORGANIZATION

____ 1. My notebook/paperwork is messy or disorganized
____ 2. My room is messy
____ 3. I tend to shove everything into my backpack, desk, or drawer
____ 4. I have multiple piles around my room
____ 5. I have trouble planning my time
____ 6. I am frequently late or in a hurry
____ 7. I often do not write down assignments or tasks and end up forgetting

MEMORY

____ 1. I have trouble with my memory
____ 2. I remember things from long ago but not recent events
____ 3. It is hard for me to memorize things for school or work
____ 4. I know something one day but do not remember it the next
____ 5. I forget what I am going to say right in the middle of saying it
____ 6. I have trouble following directions that have more than one or two steps

SOCIAL SKILLS

____ 1. I have few or no friends
____ 2. I have trouble reading body language or facial expressions of others
____ 3. My feelings are often/easily hurt
____ 4. I tend to get into trouble with friends, teachers, parents or bosses
____ 5. I feel uncomfortable around people I do not know well
____ 6. I am teased by others
____ 7. Friends do not call and ask me to do things with them
____ 8. I do not get together with others outside of school or work