Personal Information

Instructions

Please fill out this form as completely as you can. ***Print*** **your answers**.

Identification

For **Race** below, " **A** " means Asian, " **N** " means Native American.

Today's Date		**Marital Status**	**S M D W**
First Name		**Race**	**W B H A N**
Last Name		**Gender**	**M F**
Date of Birth		**Occupation**	

Address and Phones

Please give your *home* address. Circle " **M** " if it is OK for me to leave a full message there, " **C** " if a callback message is OK, and " **N** " if it isn't OK to call or leave a callback number there.

Street Address		**Cell Phone**		**M C N**
		Home Phone		**M C N**
City		**Fax**		**M C N**
State		**Business Phone**		**M C N**
Zip		**Email**		**M C N**

Emergency Contact

Please tell me the name of someone to contact in case of an emergency. If any information is the same in the table above, you can write "Same".

Name		**Relationship**	
Street Address		**Cell Phone**	
		Home Phone	
City		**Fax**	
State		**Business Phone**	
Zip		**Email**	

Continued on next page

Personal Information, Continued

Allergies and Bad Reactions

Please list any medications or foods to which you have had a bad reaction, such as an allergy or side effect that required you to stop taking the medication or eating the food. Use another sheet of paper if you have to.

Example:

Medication or Food	Reaction
Penicillin	Rash

Medication or Food	Reaction

Current Medications and Supplements

Please list **ALL** medications and supplements that you take. Include drugs that are prescribed by a doctor, any vitamins or herbal supplements, and any over-the-counter drugs that you take more than once every two weeks or so.

Example:

Medication	Dose	How Often?	Why?
Asprin	325 mg	2 x week	Headache

Medication	Dose	How Often?	Why?

Continued on next page

Personal Information, Continued

Insurance

Although I do not participate with any insurance companies, it is often helpful to me to have the following information should you need laboratory tests, an EKG, or hospitalization.

Primary Insurance		**Subscriber's name**	
Policy #		**Group #**	
Your relationship to subscriber		**Subscriber's employer**	
Subscriber's Employer		**Phone**	

Secondary Insurance		**Subscriber's name**	
Policy #		**Group #**	
Your relationship to subscriber		**Subscriber's employer**	
Subscriber's Employer		**Phone**	

Provider Information

Instructions

Please fill out this form for each of your heath providers, including doctors, therapists, pharmacies, alternative health practitioners, and anyone else you see regularly, such as a physical therapist. You do not have to include dentists, or optometrists. ***Print* your answers**.

Example:

Name	Jane Doe	**Phone**	410 123 4567
Role	Internist	**Fax**	410 123 4568
Why do you see?	Family doctor		

Example:

Name	Rite-Aid	**Phone**	410 423 4567
Role	Pharmacy	**Fax**	410 523 4568
Why do you see?	Neighborhood drugstore		

Name		**Phone**	
Role		**Fax**	
Why do you see?			

Name		**Phone**	
Role		**Fax**	
Why do you see?			

Name		**Phone**	
Role		**Fax**	
Why do you see?			

Continued on next page

Provider Information, Continued

Name		**Phone**	
Role		**Fax**	
Why do you see?			

Name		**Phone**	
Role		**Fax**	
Why do you see?			

Name		**Phone**	
Role		**Fax**	
Why do you see?			

Name		**Phone**	
Role		**Fax**	
Why do you see?			

Name		**Phone**	
Role		**Fax**	
Why do you see?			

Name		**Phone**	
Role		**Fax**	
Why do you see?			

Medical History

Medical problems

Please mark whether you or a blood-related family member (parent, sibling, grandparent, aunt or uncle) have had this medical problem now or in the past.

Now	Past	Family	Problem	Now	Past	Family	Problem
			Alcoholism				Other genetic diseases
			Anemia				Hay fever
			Anesthesia problem				Hearing problems
			Arthritis				High cholesterol
			Asthma				High blood pressure
			Bleeding problem				Immune disease
			Cancer, Breast				Kidney diseases
			Cancer, Colon				Mental retardation
			Cancer, Melanoma				Osteoporosis
			Cancer, Ovary				Epilepsy (seizure)
			Cancer, Prostate				Stroke
			Heart Attack				Substance abuse
			Birth Defects				Thyroid disorder
			Diabetes (childhood)				Smoking
			Diabetes (adult onset)				Tuberculosis
			Eczema				Migraines
			Food allergies				Gout
			AIDS/HIV				Glaucoma
			Hepatitis				Other
			Emphysema				Other

Substances

Please mark whether you are currently using any of the following substances now or in the past, whether prescribed or not.

Now	Past	Substance	Now	Past	Substance
		Alcohol			Mescaline
		Amphetamines			Methadone
		Cocaine			Opiates
		Ecstasy			PCP
		Hallucinogens			Peyote
		Heroin			Ritalin
		Illicit prescription drugs			Sedatives
		Ketamine			Other street drugs
		LSD			Tobacco products
		Marijuana			Tranquilizers

Continued on next page

Medical History, Continued

Symptoms and tests

Please circle whether you have had any of the following problems or tests in the **LAST YEAR**.

Unexplained weight gain of 20 lbs	High blood pressure	Prolonged bleeding
Unexplained weight loss of 20 lbs	Heart murmur	Swollen lymph glands
Heat intolerance	Fainting episode	Anemia
Cold intolerance	Cardiovascular disease	Leukemia
Excessive appetite	Difficulty or pain swallowing	Blood disorder
Unusual thirst	Frequent vomiting	Persistent rash
Abnormal hair growth	Persistent gas, heartburn	Moles changed in size or color
Change in sexual drive	Frequent belly pain	Lumps or soreness of breast
Frequent eye pain	Persistent constipation	Bloody discharge from nipples
Failing vision	Change in bowel habits	Psoriasis
Hearing troubles	Blood in stool	Broken bone
Ear pain or discharge	Blood on toilet paper	Back pain
Severe nosebleeds	Black or tarry stools	Headaches
Painful teeth	Loss of appetite	Double vision
Persistent sores on lips or tongue	Ulcer	Dizzy spells
Persistent hoarseness	Jaundice or hepatitis	Blackouts
Loss of vision in one or both eyes	Diverticulitis	Lost ability to speak
Retinal detachment	Gall stones	Troubles with memory
Cataract	Polyp or tumor of bowel	Coordination problems
Eye, Ear, Nose, Throat surgery	Abdominal surgery	Stroke
Daily cough	Trouble passing urine	Seizure
Severe snoring	Bloody urine	Paralysis
Asthma	Kidney or bladder infection	Multiple sclerosis
Skipped or irregular heartbeat	Treatment for venereal disease	X-Rays
Chest pain or discomfort	Kidney or bladder surgery	MRI
Shortness of breath	Discharge from penis	CT
Swollen ankles or feet	Lump or swelling of testicle	EEG
Leg cramps brought on by walking	Decrease in erections	EKG

Psychiatric History

Past Medications

The medications below are sometimes prescribed for psychiatric problems. Please circle any that you have taken in the past.

Abilify	Adapin	Adderall	Alepam	Alertec	Aloperidin
Alplax	Alprax	Alprazolam	Alviz	Alzolam	Amantadine
Ambien	Amisulpride	Amitriptyline	Amoxapine	Amfebutamone	Anafranil
Anatensol	Ansial	Ansiced	Antabus	Antabuse	Antideprin
Anxiron	Apo-Alpraz	Apo-Primidone	Apo-Sertral	Aponal	Apozepam
Aripiprazole	Aropax	Artane	Asendin	Asendis	Asentra
Ativan	Atomoxetine	Aurorix	Aventyl	Axoren	Baclofen
Beneficat	Benperidol	Bimaran	Bioperidolo	Biston	Brotopon
Bespar	Bupropion	Buspar	Buspimen	Buspinol	Buspirone
Buspisal	Cabaser	Cabergoline	Calepsin	Calcium carbonate	Calcium carbimide
Calmax	Carbamazepine	Carbatrol	Carbolith	Celexa	Chloraldurat
Chloralhydrat	Chlordiazepoxide	Chlorpromazine	Cibalith-S	Cipralex	Citalopram
Clomipramine	Clonazepam	Clozapine	Clozaril	Concerta	Constan
Convulex	Cylert	Cymbalta	Dapotum	Daquiran	Daytrana
Defanyl	Dalmane	Damixane	Demolox	Depad	Depakene
Depakote	Depixol	Desyrel	Dostinex	dextroamphetamine	Dexedrine
Diazepam	Didrex	Divalproex	Dogmatyl	Dolophine	Droperidol
Desoxyn	Edronax	Effectin	Effexor (Efexor)	Eglonyl	Einalon S
Elavil	Elontril	Endep	Epanutin	Epitol	Equetro
Escitalopram	Eskalith	Eskazinyl	Eskazine	Etrafon	Eukystol
Eunerpan	Faverin	Fazaclo	Fevarin	Finlepsin	Fludecate
Flunanthate	Fluoxetine	Fluphenazine	Flurazepam	Fluspirilene	Fluvoxamine
Focalin	Gabapentin	Geodon	Gladem	Glianimon	guanfacine
Halcion	Halomonth	Haldol	Haloperidol	Halosten	Imap
Imipramine	Imovane	Janimine	Jatroneural	Kalma	Keselan
Klonopin	Lamotrigine	Largactil	Levomepromazine	Levoprome	Leponex
Lexapro	Libotryp	Libritabs	Librium	Linton	Liskantin
Lithane	Lithium	Lithizine	Lithobid	Lithonate	Lithotabs
Lorazepam	Loxapac	Loxapine	Loxitane	Ludiomil	Lunesta
Lustral	Luvox	Lyrica	Lyogen	Manegan	Manerix
Maprotiline	Mellaril	Melleretten	Melleril	Melneurin	Melperone
Meresa	Mesoridazine	Metadate	Methamphetamine	Methotrimeprazine	Methylin
Methylphenidate	Minitran	Mirapex	Mirapexine	Moclobemide	Modafinil
Modalina	Modecate	Moditen	Molipaxin	Moxadil	Murelax
Myidone	Mylepsinum	Mysoline	Nardil	Narol	Navane
Nefazodone	Neoperidol	Neurontin	Nipolept	Norebox	Normison
Norpramine	Nortriptyline	Novodorm	Olanzapine	Omca	Oprymea
Orap	Oxazepam	Pamelor	Parnate	Paroxetine	Paxil
Peluces	Pemoline	Pergolide	Permax	Permitil	Perphenazine
Pertofrane	Phenelzine	Phenytoin	Pimozide	Piportil	Pipotiazine
Pragmarel	Pramipexole	Pregabalin	Primidone	Prolift	Prolixin
Promethazine	Prothipendyl	Protriptyline	Provigil	Prozac	Prysoline
Psymion	Quetiapine	Ralozam	Reboxetine	Redeptin	Resimatil
Restoril	Restyl	Rhotrimine	Risperdal	Risperidone	Rispolept
Ritalin	Rivotril	Rubifen	Rozerem	Sediten	Seduxen
Selecten	Serax	Serenace	Serepax	Serenase	Serentil
Seresta	Serlain	Serlift	Seroquel	Seroxat	Sertan
Sertraline	Serzone	Sevinol	Sideril	Sifrol	Sigaperidol
Sinequan	Sinqualone	Sinquan	Sirtal	Solanax	Solian
Solvex	Songar	Stazepin	Stelazine	Stilnox	Stimuloton
Strattera	Sulpiride	Sulpiride Ratiopharm	Sulpiride Neurazpharm	Surmontil	Symbyax
Symmetrel	Tafil	Tavor	Taxagon	Tegretol	Telesmin
Temazepam	Temesta	Temposil	Terfluzine	Thioridazine	Thiothixene
Thombran	Thorazine	Timonil	Tofranil	Tradon	Tramadol

Tramal	Trancin	Tranax	Trankimazin	Tranquinal	Tranylcypromine
Trazalon	Trazodone	Trazonil	Trialodine	Trevilor	Triazolam
Trifluoperazine	Trihexane	Trihexyphenidyl	Trilafon	Trimipramine	Triptil
Trittico	Troxal	Tryptanol	Tryptomer	Ultram	Valium
Valproate	Valproic acid	Valrelease	Vasiprax	Venlafaxine	Vestra
Vigicer	Vivactil	Wellbutrin	Xanax	Xanor	Xydep
Zaleplon	Zamhexal	Zeldox	Zimovane	Zispin	Ziprasidone
Zolarem	Zoldac	Zoloft	Zolpidem	Zonalon	Zopiclone
Zotepine	Zydis	Zyprexa	Zuclopenthixol		

Hospitalization History

If you have ever been hospitalized for a psychiatric problem, please indicate below. Use the back of the page if you need to.

When	Where	Reason

Past Therapists

Please list all mental heath professionals that you have seen for more than one visit.

Who	When	Where	Why

Version

September 26, 2013

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

Name: _____ Age: ____ Sex: ❑ Male ❑ Female Date:_____

If this questionnaire is completed by an informant, **what is your relationship with the individual? _____**
In a typical week, approximately how much time do you spend with the individual? _____ hours/week

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**.

	During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	

LEVEL 2—Substance Use—Adult*

*Adapted from the NIDA-Modified ASSIST

Name: _____ Age: ____ Sex: ❑ Male ❑ Female Date:_____

If the measure is being completed by an informant, what is your relationship with the individual receiving care? _____

In a typical week, approximately how much time do you spend with the individual receiving care? _____ hours/week

Instructions: On the DSM-5 Level 1 cross-cutting questionnaire that you just completed, you indicated that *during the past 2 weeks* you (the individual receiving care) have been bothered by "using medicines on your own without a doctor's prescription, or in greater amounts or longer than prescribed, and/or using drugs like marijuana, cocaine or crack, and/or other drugs" at a slight or greater level of severity. The questions below ask how often you (the individual receiving care) have used these medicines and/or substances **during the past 2 weeks. Please respond to each item by marking (✓ or x) one box per row.**

During the past **TWO (2) WEEKS**, about how often did you use any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed?							**Clinician Use**
		Not at all	**One or two days**	**Several days**	**More than half the days**	**Nearly every day**	**Item Score**
a.	Painkillers (like Vicodin)	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
b.	Stimulants (like Ritalin, Adderall)	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
c.	Sedatives or tranquilizers (like sleeping pills or Valium)	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
Or drugs like:							
d.	Marijuana	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
e.	Cocaine or crack	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
f.	Club drugs (like ecstasy)	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
g.	Hallucinogens (like LSD)	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
h.	Heroin	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
i.	Inhalants or solvents (like glue)	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
j.	Methamphetamine (like speed)	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
						Total Score:	

Name _____ Date_____

The HCL-32 questionnaire for Energy, Activity and Mood

At different times in their life everyone experiences changes or swings in energy, activity and mood ("highs and lows" or "ups and downs"). The aim of this questionnaire is to assess the characteristics of the "high or hyper" periods.

1) First of all, how are you feeling today compared to your usual state:
(Please mark only ONE of the following)

Much worse than usual	Worse than usual	A little worse than usual	Neither better nor worse than usual	A little better than usual	Better than usual	Much better than usual
☐	☐	☐	☐	☐	☐	☐

2) How are you usually compared to other people?
Independently of how you feel today, please tell us how you are normally compared to other people, by marking which of the following statements describes you best.

Compared to other people my level of activity, energy and mood...
(Please mark only ONE of the following)

... is always rather stable and even	... is generally higher	... is generally lower	... repeatedly shows periods of ups and downs
☐	☐	☐	☐

3) Please try to remember a period when you were in a "high or hyper" state.
How did you feel then?
Turn to the other side and check all the statements that happen during a high or hyper state.

In such a "high or hyper" state:	YES	NO
1. I need less sleep	☐	☐
2. I feel more energetic and more active	☐	☐
3. I am more self-confident	☐	☐
4. I enjoy my work more	☐	☐
5. I am more sociable (make more phone calls, go out more)	☐	☐
6. I want to travel and/or do travel more	☐	☐
7. I tend to drive faster or take more risks when driving	☐	☐
8. I spend more money/too much money	☐	☐
9. I take more risks in my daily life (in my work and/or other activities)	☐	☐
10. I am physically more active (sports, etc.)	☐	☐
11. I plan more activities or projects	☐	☐
12. I have more ideas, I am more creative	☐	☐
13. I am less shy or inhibited	☐	☐
14. I wear more colorful and more extravagant clothes/make-up	☐	☐
15. I want to meet or actually do meet more people	☐	☐
16. I am more interested in sex, and/or have increased sexual desire	☐	☐
17. I am more flirtatious and/or am more sexually active	☐	☐
18. I talk more	☐	☐
19. I think faster	☐	☐
20. I make more jokes or puns when I am talking	☐	☐
21. I am more easily distracted	☐	☐
22. I engage in lots of new things	☐	☐
23. My thoughts jump from topic to topic	☐	☐
24. I do things more quickly and/or more easily	☐	☐
25. I am more impatient and/or get irritable more easily	☐	☐
26. I can be exhausting or irritating to others	☐	☐
27. I get into more quarrels	☐	☐
28. My mood is higher, more optimistic	☐	☐
29. I drink more coffee	☐	☐
30. I smoke more cigarettes	☐	☐
31. I drink more alcohol	☐	☐
32. I take more drugs (sedatives, anxiolytics, stimulants...)	☐	☐

4) Did the previous chart, which characterize a "high", describe how you are...
(Please mark only ONE of the following)

... sometimes? ☐ ⇨ if you mark this box, please answer all questions 5 to 9

... most of the time? ☐ ⇨ if you mark this box, please answer only questions 5 and 6

I never experienced such a "high" ☐ ⇨ if you mark this box, please stop here

5) Impact of your "highs" on various aspects of your life:

	Positive and negative	Positive	Negative	No impact
Family life	☐	☐	☐	☐
Social life	☐	☐	☐	☐
Work	☐	☐	☐	☐
Leisure	☐	☐	☐	☐

6) How did people close to you react to or comment on your "highs"?
(Please mark ONE of the following)

Positively (encouraging or supportive)	Neutral	Negatively (concerned, annoyed, irritated, critical)	Positively and negatively	No reactions
☐	☐	☐	☐	☐

7) Length of your "highs" as a rule (on the average):
(Please mark ONE of the following)

☐ 1 day
☐ 2–3 days
☐ 4–7 days
☐ longer than 1 week
☐ longer than 1 month
☐ I can' t judge / don't know

8) Have you experienced such "highs" in the past twelve months?

☐ Yes ☐ No

9) If yes, please estimate how many days you spent in "highs" during the last twelve months:
Taking all together: about _____ days

Source: J. Angst et al. / Journal of Affective Disorders 88 (2005) 217–233; cut-off > = 14.