Appendix A
History and Personal Data Questionnaire

Date: _____

Name: _____ Date of Birth: _____ Age: _____

Main reason for seeking help at this time: _____
_____
_____

Current Problems or Symptoms

Please read each item below and determine which statement is true for you. Then, place an "X" in the appropriate box to indicate how often you feel the statement applies to you *during the past month or since your last visit.* If item does not apply indicate N/A for Not Applicable.

	EXAMPLE	N/A	None of the time (O)	Occasionally (1)	Some of the time (2)	Most or all of the time (3)
1.	I feel sad				X	

		DURING THE PAST MONTH OR SINCE LAST VISIT		None of the time	Occasionally	Some of the time	Most or all of the time
A	1.	Wake up at night or the early morning and unable to return to sleep.					
	2.	Very restless sleep					
	3.	Fatigue or loss of energy					
	4.	Decreased sex drive					
	5.	Unable to enjoy life; have lost zest for life					
	6.	Have withdrawn from others					
	7.	Strong thoughts about suicide					
	8.	Loss of appetite					
	9.	Memory problem, forgetfulness, poor concentration.					
	10.	Feel irritable or easily frustrated					
	11.	Feelings of sadness or hopelessness					
	12.	Sleeping a lot					
B	13.	Decreased need for sleep					
	14.	Increased sex drive					
	15.	Increased energy					
	16.	So happy or energetic that people describe me as "manic" or "hyper"					
C	17.	Can't get to sleep					

Please complete the next page

		DURING THE PAST MONTH OR SINCE LAST VISIT	N/A	None of the time	Occasionally	Some of the time	Most or all of the time
	18.	Sudden episodes of nervousness or panic					
	19.	Fear of losing self-control					
	20.	Racing or rapid heart beat					
	21.	Shortness of breath					
	22.	Feel tense or anxious all day					
	23.	Feel very anxious in social situations					
	24.	Have recurring, troubling, thoughts, images or impulses that I can't get out of my mind.					
D	25.	Repetitive behaviors such as excessive hand washing, etc.					
	26.	Feel very confused about my thoughts					
	27.	Strange or bizarre thoughts					
	28.	Hallucinations, hear voices, or see things that aren't there					
	29.	Very peculiar experiences that others do not understand					
E	30.	Feel ready to explode					
	31.	Thoughts about harming someone					
	32.	Cutting or other self harm.					
	33.	Excessive use of alcohol/drugs					
F	34	Unusual eating habits					
	35.	Weight loss – How much in the past month? _____ lbs. Weight gain – How much in the past month? _____ lbs. Have you been trying to diet? _____ Yes _____ No					
	36.	In the past I have tried to cut down on my use of alcohol or other drugs __ Yes __ No __ N/A					

Previous Treatment for Psychological or Emotional Problems

Year	Problem	Therapist / Location	Hospitalization or Medical Treatment

Do You Take Any of the Following Medications?

☐ Antihypertensives (for high blood pressure or migraine headaches?)

☐ Steroids ☐ Hormones ☐ Tranquilizers

Thank You