

A.D.D. Clinic, Inc.

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NEW PATIENT HISTORY FOR ADULTS & EVALUATION QUESTIONNAIRES

DIRECTIONS:

Please complete this entire “packet” very carefully before arriving for your first appointment at the A.D.D. Clinic. It will take at least 2 hours to answer the hundreds of questions you are asked to respond to in these Initial Evaluation materials. The time you devote to the task will be well worthwhile. The A.D.D. Clinic physician will be able to develop an accurate diagnosis and effective treatment plan *quickly* with these completed materials in hand right from the start. **Please answer ALL QUESTIONS.**

Please try to be at least 30 minutes early for your first appointment, OR (better) have the packet mailed or dropped off at the Clinic several days ahead of time so the physician can review the material in advance of the appointment.

Please do not “race through” the questions! It is very important some of the “details” be thoroughly checked out, especially precise names and doses of any medications previously or currently prescribed for your medical and/or psychiatric treatment, names, addresses, phone & FAX numbers of therapists and physicians, and similar important matters.

You should find in this “packet” Directions to the A.D.D. Clinic, including an area map, and a note confirming your appointment date and time. The following forms and questionnaires should be enclosed:

- 1) Patient Registration Form
- 2) Residence & Employment Information
- 3) Why Are You Here?
- 4) *Health Review Form
- 5) *Past/Present Medical History
- 6) *Family History
- 7) *School, Employment, & Legal History
- 8) *Reasoning, Empathy, & Attention Questions
- 9) *Mood, Obsession, Compulsion, & Tic Family Questions
- 10) *Wender Rating Scale
- 11) “Mini” Rating Scale
- 12) Modified Hamilton Questionnaire
- 13) *Temperament Rating Scale
- 14) Beck Anxiety Inventory

* **WHENEVER POSSIBLE**, these particular questionnaires should be completed by BOTH the patient and his or her spouse *together* when the patient is married, or by the patient and his/her mother or father if the patient is single, *especially if the patient is a young adult, i.e., under 30*. The other questionnaires are to be completed by the patient only.

* We strongly encourage married couples BOTH attend & participate in this evaluation, and especially advise evaluation of young adults is BY FAR more accurate and valid when the best informed, most knowledgeable parent is also present. {Young adult patients may request private time with the physician to discuss matters they do not wish parents to know about, of course, and the physician may insist on some such time with young adult patients when it appears sensitive issues should be discussed in private.}

The evaluation will consist of an initial interview reviewing completed forms and questionnaires in addition to a personal and/or family discussion with the physician, and then “testing” with one or more computer administered, standardized evaluation programs. These tests take up to 60-90 minutes.

The Clinic physician, upon review of the questionnaires and discussion in the initial interview, may decide to assign one or more additional questionnaires which should be completed before the second, “wrap-up” diagnostic treatment recommendation interview.

Patients’ vital signs (Pulse and Blood Pressure) may be checked by Clinic staff during the course of this evaluation. In the event the Clinic physician determines there is a sound reason to perform additional medical evaluations, such as an EKG (on site), cardiovascular examination, or other medical examinations, these may also be recommended.

The A.D.D. Clinic, Inc. is a fully-integrated MEDICAL and PSYCHIATRIC CLINIC. In effect, we are very careful to evaluate potential physical or “medical” causes of psychological or psychiatric problems, as well as provide effective psychiatric and psychological care for patients who have complications of medical problems.

We do NOT provide ongoing “Primary Care” for any patients we see here, but we do, whenever possible, provide consultation and routine support for Primary Care physicians who serve as principle physicians in our patient’s cases.

FEES:

Initial visit \$500.00

Follow-up services:

15-minute physician services \$120.00

30-minute physician services \$225.00

45-minute physician services \$325.00

60-minute physician services \$400.00

EKG \$100.00

Prescriptions written between appointments, called in to a pharmacy, FAXED to a pharmacy or picked up – per patient charge is \$10.00.

***All fees are subject to change without prior notice.

AVAILABLE SERVICES:

Comprehensive Psychiatric Evaluation and Treatment for Patients, Parents, Siblings and other family members

Expert medication treatment for patients and family members who have ADHD and related conditions

Expert Cognitive/Behavioral Therapy for OCD and Related Disorders

Individual Psychotherapy/Counseling for all major conditions

Family Therapy

Parenting Counseling & Training

Individual & Couples Counseling for Substance Abuse Disorders

Couples Therapy for Adults

Electrocardiogram [EKG]

Monitoring of Height, Weight, Pulse, and Blood Pressure

Follow-up psychiatric services available for patients in distant locations via web-cam conferencing, and tele-conferencing

In addition to treating patients of all ages for all facets and complications of ADHD, we have highly specialized psychiatric and psychological programs in place to treat patients with:

Asperger's Disorder

Obsessive-Compulsive Disorder

Tourette's Syndrome

Other mental & emotional conditions

Major Depression

Bipolar Disorder

Anxiety Disorders

PATIENT REGISTRATION FORM

DATE: _____

PATIENT NAME: _____

SS# _____ AGE _____ DOB _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME # _____ WORK# _____ CELL# _____

RESPONSIBLE PARTY /PARENT / GUARDIAN INFORMATION:

NAME: _____ SS# _____

DATE OF BIRTH _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME #: _____ WORK# _____ CELL#: _____

EMPLOYER NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

EMPLOYER PHONE: _____ EXT: _____

RELATIONSHIP TO PATIENT: (please circle all applicable)

SELF SPOUSE MOTHER FATHER GRANDPARENT AUNT UNCLE STEP-PARENT

OTHER

INSURANCE INFORMATION:

INSURED NAMED: _____

DOB OF INSURED: _____

INS. COMPANY: _____

GROUP# _____

MEMBER# _____

POLICY# _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

INSURANCE PHONE# _____ WORK PHONE # _____

RELATIONSHIP TO INSURED: _____

PLEASE READ BEFORE SIGNING:

This form is a contract between patient and physician and must be signed prior to receiving any services.

****(NOTE: The "I" statement in this agreement also refers to any dependents being treated.)**

I understand that I may be charged full fee for appointments that are not cancelled 24 hours prior to the time of the appointment, unless the appointment is changed due to a bona fide emergency.

I understand that all fees are to be paid at the time of service.

I authorize the A.D.D. Clinic, Inc. to perform services required for evaluation of the presenting condition(s). The treating physician will discuss proposed treatment with patients and families before therapy is initiated.

I understand that I am responsible for all court costs, interest and legal fees if my account goes into collections.

I understand that I will be charged a returned check fee of \$25.00 for all checks returned by the bank.

I stipulate that I am the custodial parent or legal guardian if the patient is a minor, and I am legally authorized to obtain medical care.

I understand that the A.D.D. Clinic, Inc. is not a provider for ANY insurance company. Payment is expected at the time of each visit. If you have insurance and want it billed, we will submit it for you and any monies paid to us will either get credited on your account for further visits, or reimbursed to you. Any authorizations necessary and required by your insurance company, is solely your responsibility, but we will try to assist in every way we can.

I understand that if there is any change in my: address, telephone #, and responsible party, it is my sole responsibility to inform the A.D.D. Clinic, Inc.

I understand that I must allow 24 hours for medication refills and picking up prescriptions when called into the office. When a pharmacy calls the office it will take up to 6 hours or more before they can be called in. A doctor must authorize all refills/prescriptions. We cannot process prescription refill requests called in after 4 PM Friday until 10 AM Monday morning. If you request to have prescriptions mailed to you, there will be a \$10.00 fee for this service each time.

I understand that I will be charged \$0.60 cents per page for copying of medical records.

I understand that I will be charged for special reports and letters. This fee is based on time and difficulty of report(s). The physician, therefore, will determine this fee.

I certify that all the information I have provided is true and correct. (INITIAL)_____

I have read and understand all the paragraphs above. (INITIAL)_____

SIGNED: _____ DATE: _____

Responsible party (Patient Signature) If minor: Signature of Parent / Guardian

RESIDENCE and EMPLOYMENT INFORMATION

PATIENT NAME: _____

BIRTH DATE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME# _____ CELL# _____ (if applicable)

E-MAIL ADDRESS: _____

Best number to reach you between 9-5 to confirm appointment: _____

Employer Name: _____

Work Tel: _____ Cell: _____

Occupation: (describe what you do at work): _____

SPOUSES NAME, IF MARRIED: _____

Employer Name: _____

Work Tel: _____ Cell: _____

Occupation: (describe what you do at work): _____

NAMES AND AGES OF CHILDREN:

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

PARENTS NAME(S), IF PATIENT RESIDES WITH ONE OR BOTH PARENTS:

Father: _____ Occupation: _____

Address: _____

Work phone: _____ Home phone: _____ Cell: _____

Mother: _____ Occupation: _____

Address: _____

Work phone: _____ Home phone: _____ Cell: _____

WHY ARE YOU HERE?

Who referred you to the A.D.D. Clinic? _____

Why, exactly, were you referred to us? _____

Do you currently see a counselor or therapist? Yes _____ No _____

If so, who, why, and how for how long? _____

What do you hope we will be able to do to help you?

Which problems are most troublesome right now?

HEALTH REVIEW FORM

CURRENT STATUS: Are you being treated for any medical condition at this time?
Yes___No___If Yes, what conditions?

What treatment is being provided? [Name of medication, dose, when taken, and name of prescribing physician]:

Name of your Primary Care Physician: _____
Address: _____
Phone number _____ FAX _____

Is any Specialized physician providing care for you? Yes___No___If Yes, for what condition?

What treatment is being provided? [Name of medication, dose, and when taken]

Name of Specialist: _____
Address: _____
Phone number _____ FAX _____

Most recent lab tests were obtained (when?) _____ for what reason?

What were the results?

Approximate date of last complete physical examination: _____

Findings:

Do you take **any** Over the Counter, mineral, vitamin, herbal, or homeopathic substances of ANY KIND? Yes___No___If Yes, please list ALL such substances:

Do you have any present health concerns? Yes___No___If Yes, what are your concerns?

PAST/PRESENT MEDICAL HISTORY

Please CAREFULLY review these symptoms & problems, and note whether you have EVER had these conditions in the past, or do now.

ASTHMA Yes___No___Past___Present___Any current treatment?

ALLERGIES to any medications Yes___No___If Yes, which medications?

EPILEPSY/SEIZURES Yes___No___If Yes, when, and what treatment was/is provided?

BRAIN INFECTIONS (e.g. ENCEPHALITIS, MENINGITIS) Yes___No___If Yes, when, and what was the outcome?

SERIOUS BRAIN INJURY from TRAUMA Yes___No___If Yes, when, what happened, what damage resulted, and is there any residual?

THYROID HORMONE ABNORMALITY Yes___No___If Yes, what type?
What treatment is being provided?

RECURRENT, VERY FREQUENT INNER EAR INFECTIONS AS A YOUNGER CHILD
Yes___No___or STREP THROAT INFECTIONS Yes___No___

SEVERE HEADACHES Yes___No___Any specific diagnosis? Any pattern suggestive of
Migraine? Yes___No___Examination and evaluation history:

OTHER HEALTH PROBLEMS: Please check any symptoms that may apply:

- | | |
|---|---|
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Vivid nightmares |
| <input type="checkbox"/> Dry skin | <input type="checkbox"/> Weight gain |
| <input type="checkbox"/> Feeling cold in warm rooms | <input type="checkbox"/> Diarrhea or constipation |
| <input type="checkbox"/> Unexplained fainting | <input type="checkbox"/> Excessive sweating |
| <input type="checkbox"/> History of high blood pressure | <input type="checkbox"/> Chronically low blood pressure |
| <input type="checkbox"/> History of ulcers | <input type="checkbox"/> Dark, sticky bowel movements |
| <input type="checkbox"/> Joint pain | <input type="checkbox"/> Frequent shortness of breath |
| <input type="checkbox"/> Recurrent, dull chest pain | <input type="checkbox"/> Recent weight loss |
| <input type="checkbox"/> Tremors in hands | <input type="checkbox"/> Episodes of odd forgetfulness |
| <input type="checkbox"/> Other | |

EVALUATION and TREATMENT HISTORY

1) Have you been evaluated and/or treated by other mental health professionals in the past?
Yes___ [go to item 2] No___ [skip item 2]

2) When, where, why and whom have you consulted for counseling, psychological, and/or psychiatric assistance in the past? Please describe / discuss these experiences in as close to chronological order as possible.

3) Which of these experiences were most helpful? Why?

4) Have you been treated with psychiatric medications in the past? Yes___ [go to item 5]
No___ [skip item 5]

5) Please "check" any of the following medications with which you have been treated in the past:

<input type="checkbox"/> Ritalin	<input type="checkbox"/> Dexedrine	<input type="checkbox"/> Adderall	<input type="checkbox"/> Concerta	<input type="checkbox"/> Focalin
<input type="checkbox"/> Desoxyn	<input type="checkbox"/> Provigil	<input type="checkbox"/> Lithium	<input type="checkbox"/> Depakote	<input type="checkbox"/> Tegretal
<input type="checkbox"/> Zyprexa	<input type="checkbox"/> Risperdal	<input type="checkbox"/> Geodon	<input type="checkbox"/> Seroquel	<input type="checkbox"/> Abilify
<input type="checkbox"/> Prozac	<input type="checkbox"/> Wellbutrin	<input type="checkbox"/> Paxil	<input type="checkbox"/> Zoloft	<input type="checkbox"/> Luvox
<input type="checkbox"/> Celexa	<input type="checkbox"/> Lexapro	<input type="checkbox"/> Effexor	<input type="checkbox"/> Remeron	<input type="checkbox"/> Serzone
<input type="checkbox"/> Cymbalta	<input type="checkbox"/> Symbyax	<input type="checkbox"/> Metadate	<input type="checkbox"/> Methylin	<input type="checkbox"/> Lamictal
<input type="checkbox"/> Trileptal	<input type="checkbox"/> Gabatril	<input type="checkbox"/> Xanax	<input type="checkbox"/> Klonopin	<input type="checkbox"/> Valium
<input type="checkbox"/> Librium	<input type="checkbox"/> Trazodone	<input type="checkbox"/> Ambien	<input type="checkbox"/> Sonata	<input type="checkbox"/> Elavil
<input type="checkbox"/> Dalmane	<input type="checkbox"/> Strattera	<input type="checkbox"/> Daytrana	<input type="checkbox"/> Carbatrol	<input type="checkbox"/> Tofranil
<input type="checkbox"/> Imipramine	<input type="checkbox"/> Amitryptiline	<input type="checkbox"/> Other		

6) Were any of these medications helpful? If so, which medications, and how?

7) Did you have side effect problems with any of these medications? If so please describe:

8) Why did you stop taking these medications?

FAMILY HISTORY

Have any biologically – related family members been diagnosed with any of the following conditions? If so, mention who, using first names only, and their relationship to the patient, e.g. “Dad’s cousin Harry” and mark Dx. If you know of family members you strongly suspect have these conditions, mention who, and mark S.

Attention Deficit Disorder, “A.D.D.,” or “Hyperactivity”

Bipolar Disorder, or “Manic-Depressive Disorder”

Major Depression

Obsessive-Compulsive Disorder

Tics and Tourette’s Syndrome

Asperger’s Disorder or any form of Autism

Panic Disorder

Other Anxiety Disorders, such as Agoraphobia

Other Serious Mental Disorders

Please note if any biological relatives have a history of:

MARK: M for mother, F-father, GM-grandmother, GF-grandfather, S-Sister, B-brother, A-aunt, U-uncle, C-cousin, etc.

<input type="checkbox"/> Thyroid Disorders	<input type="checkbox"/> Sudden death from cardiovascular “accidents”
<input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> Disorders of Cholesterol metabolism
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Low Blood Pressure
<input type="checkbox"/> Serious Kidney Disorders	<input type="checkbox"/> Familial Obesity
<input type="checkbox"/> Stroke	<input type="checkbox"/> Anemia
<input type="checkbox"/> Ulcer	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Other important health conditions (Specify)	

SCHOOL, EMPLOYMENT, & LEGAL HISTORY

SCHOOL HISTORY

Please indicate any significant problems in Elementary, Middle or High School:

Did you repeat any grade? If so, what grade?

Was repeating a grade recommended at any time?

Did you have difficulty in any particular subject or kind of academic area, e.g. Reading___

Writing___Math___Handwriting___Learning Cursive___Other___

Discuss:

Were you *especially good* in certain areas? If so, what areas?

If you had problems in school, when did these problems develop, and what happened?

Did you graduate from High School? Yes___No___

Did you earn a G.E.D? Yes___No___

Did you attend college? Yes___No___ Earned a degree? Yes___No___

If Yes, what Degree? _____ Any Postgraduate training? Yes___No___

Postgraduate Degree? Yes___No___ If Yes, what Degree? _____

EMPLOYMENT HISTORY

What has been your normal employment in the past?

What problems did you experience in that line of work?

What do you hope to do in the future?

LEGAL PROBLEMS (May be left incomplete & discussed privately with the physician if you feel written documentation would be imprudent)

Describe past & any current problems:

REASONING, EMPATHY, & ATTENTION QUESTIONS

Please rate yourself **as a child** between ages 7-15 on a scale of 0 – 5 on each of these questions, with 0 = Infrequent or Not Characteristic of yourself as a child, to 5 = As Almost Always or Very typical of yourself, using 1– 4 for intermediate ratings.

- ___ 1) Blurting out responses to questions impulsively.
- ___ 2) Jumped to conclusions without thinking carefully.
- ___ 3) Often could not exactly explain why he/she had reached a decision or conclusion.
- ___ 4) Considered naïve by same-age peers.
- ___ 5) Easily frustrated when required to pay close attention to long, detailed projects.
- ___ 6) Quick to stick up for or help other children when they were in danger or hurt.
- ___ 7) Shared own toys, games, and personal objects generously with siblings and other children.
- ___ 8) Fierce, nasty temper outbursts.
- ___ 9) Pouted, whined, & cried easily and often when frustrated.
- ___ 10) Feelings easily hurt when teased or taunted by other children.
- ___ 11) Lashed out with anger and aggression when feelings hurt.
- ___ 12) Withdrew, cried, and sought out parents for solace when feelings hurt.
- ___ 13) Picked on and/or target of “bullying” by other children.
- ___ 14) Selectively played with younger peers.
- ___ 15) Seemed unusually attracted to playing with children of the opposite sex.
- ___ 16) Expressed fears of injury and/or illness.
- ___ 17) Asked many questions about morbid themes, e.g. death, dying, illnesses, etc.
- ___ 18) Very curious about VERY ODD things.
- ___ 19) EXTREMELY PRIVATE and guarded about what he/she draw, read or wrote.
- ___ 20) Reluctant, or refused to join same-age peers in rough-and-tumble games and horseplay.
- ___ 21) Dressed in clothing of opposite sex.
- ___ 22) Insisted on using age-inappropriate make-up.
- ___ 23) Extremely curious about sexuality at a very young age.
- ___ 24) Sexual activity had been at times, a matter of parental concern.
- ___ 25) Normally happy, “upbeat,” playful, good mood.
- ___ 26) Sought exceptional attention and reassurance at bedtime.
- ___ 27) Insisted parents follow certain precise rituals or he/she becomes very upset.

CURRENT PROBLEMS

Please continue to use the 0-5 rating scale as on prior page.

- ___ 28) Failure to give close attention to details or made careless mistakes in schoolwork or other activities.
- ___ 29) Difficulty sustaining attention in routine tasks or play activities.
- ___ 30) Difficulty with listening when spoken to directly.
- ___ 31) Difficulty following through on instructions and failure to finish schoolwork or chores.
{This is NOT due to failure to understand the instructions}.
- ___ 32) Difficulty *organizing* tasks and activities.
- ___ 33) Avoids, dislikes, reluctant to engage in tasks requiring sustained mental effort.
- ___ 34) Loses things necessary for tasks and activities, like tools, equipment, directions etc.
- ___ 35) Easily distracted by all kinds of sights, sounds, co-workers activities, own thoughts and impulses, etc.
- ___ 36) Forgetful in almost all daily activities, at home and at work.
- ___ 37) Called an "Absent-Minded Professor" or "Space Cadet" by friends and family members.
- ___ 38) Appears to spend an exceptional amount of time daydreaming.
- ___ 39) Fidgets, squirms and wiggles hands and feet, and seems extremely restless.
- ___ 40) Difficulty remaining seated at work, at the dinner table, or elsewhere where this is socially expected.
- ___ 41) Overactive and far more restless than similar-age adults.
- ___ 42) Rarely quiet.
- ___ 43) Is often on the go or acts as if "driven by a motor".
- ___ 44) Talks excessively, even when being quiet is socially required.
- ___ 45) "Pops out" with answers or conclusions before listening to the whole question or problem.
- ___ 46) Has difficulty waiting for his/her turn.
- ___ 47) Interrupts and intrudes on others' activities or conversations.
- ___ 48) Disruptive in social or family gatherings.
- ___ 49) Becomes VERY WOUND UP in stimulating situations.
- ___ 50) Difficulty settling down and getting to sleep on a routine schedule.

Please place a *, **, or *** on the left margin next to characteristics which best describe the most important concerns you have about yourself.

MOOD, OBSESSION, COMPULSION, & TIC SYMPTOMS

MOOD QUESTIONS

Please respond to the following questions using a scale of 0 – 5 , with 0 = Infrequent or Not Characteristic of yourself, to 5 = Almost Always or Typical for yourself, using 1-4 for intermediate ratings. Further, please note which family members *also* may have these characteristics by noting, in the margin, numbers and initials. For Mom or Dad, just use M or D. For siblings, use initials such as T. W. for a younger brother named Tommy Wallace, etc.

Severity

Who else?

- _____ "Mood swings" which seem unrelated to external events or stresses.
- _____ "Mood swings" are often remarkably severe, from very high to very low.
- _____ Outbursts of rage which seem unpredictable.
- _____ Friends and family are increasingly concerned about unstable moods.
- _____ Increasingly long periods of withdrawal from friends and family.
- _____ Loss of interest and participation in usual hobbies and activities.
- _____ Grades and/or work productivity dropping substantially.
- _____ History of suicide attempts ___ ideas ___ current suicidal ideas.
- _____ Feeling like "giving up," "nothing left to lose."
- _____ Episodes of wild, strange, bizarre ideas and actions.
- _____ Negative, unhappy feelings that are persistent but never very deep.

OBSESSIONS

- _____ Preoccupation with contamination vs cleanliness themes.
- _____ Exaggerated need for order, precision, things being lined up and even.
- _____ Recurrent, *unwanted* thoughts which provoke guilt and anxiety.
- _____ Recurrent ideas or thoughts which may be incredibly weird, and disturbing, involving unacceptable sexual and/or aggressive themes.
- _____ Inability to "turn off" disturbing thoughts.
- _____ Guilt and anxiety about these thoughts is increasingly distressing.

COMPULSIONS

- _____ Irresistible urges to do something to try to make disturbing obsessions go away.
- _____ Cleaning taken to excessive lengths to try to defray fears of contamination by germs.
- _____ Checking and re-checking to try to solve pathological doubt about everything being straight and neat and perfect.
- _____ Multiple erasures and changes to try to get everything EXACTLY PERFECT in written work.

TICS

Tics may be vocal or motor, e.g. noises, or movements. Common vocal tics include snorts, grunts, etc. Motor tics include blinking and nose twitching. Tics are usually familial (from your DNA). Please note below if you have had any of the following tics, severity on the familiar 0-5 scale, if any other family member has similar tics, and at what age you developed each tic. **Please use an X for current tics and a √ for past tics.**

Tics are sudden, INVOLUNTARY, twitching movements, or brief, INVOLUNTARY NOISES.

Severity	Who else?	Severity	Who else?
___	___ Eye blinking	___	___ Throat clearing
___	___ Nose twitching	___	___ Nasal sniffing
___	___ Mouth twitching	___	___ Snorting
___	___ Neck jerking	___	___ High-pitched noises
___	___ Tongue jerking and biting	___	___ Swear words

There are many other motor and vocal tics: Shoulder jerking, arm and leg thrusts and kicks, and a very wide variety of truly odd sounds and noises, even including barking and howling.

There are also complicated “tics” and/or complex compulsions: 1) Frequent sniffing of one’s own fingers; 2) Repeatedly touching of one’s own privates; 3) Recurrent exhibitionism in younger children; 4) Recurrent, repetitive touching of forbidden parts of other person’s bodies, especially private parts (almost always mother’s breast); 5) Repeating bizarre and semi-obscene phrases, as if in a hypnotic manner, when tired.

SELF INJURIOUS BEHAVIOR QUESTIONS

Please rate these characteristics in yourself and family members using the 0-5 scales as previously employed.

Severity	Who else?
___	___ Substance or alcohol abuse problems are causing concern.
___	___ Someone in my family has a nasty secret.
___	___ Someone in my family sneakily pulls out scalp or other hair.
___	___ One of my family members picks and scratches skin “way beyond normal.”
___	___ I cut myself when anxious and/or angry.
___	___ Someone in my family is in deep trouble due to gambling.
___	___ Someone in my family is in legal trouble.
___	___ Someone in my family REALLY needs medical attention now! Why?

OTHER: Yes___No___Are any loaded weapons kept in your home?
Yes___No___Do any visiting relatives or friends disrupt your family environment?
Yes___No___Would you describe the family environment as tense?

TEMPERAMENT RATING SCALES

CHILD-ADOLESCENT CONCERNS: (Rating yourself as a child)

SEVERITY - Using 0-5 scale as before.

- I was an incredibly nasty, testy and angry child.
- I daydreamed my way through chores, school, church and homework.
- I usually got along pretty well with most other kids.
- I liked to taunt and tease other kids and make them cry.
- My parents, other kids, and even grandparents were afraid of my terrible temper.
- I was shy and cried easily when I was upset.
- I always felt incredibly IRRITABLE.
- I hung around with older kids and tried to do the things they did.
- I kept trying to remember and follow directions, but I kept goofing up even when I tried hard.
- I snuck around and did some major sexual no-no's even when I was pretty young.
- I always felt like I never quite knew what most kids my age were talking about.
- I was never really comfortable unless I was playing with younger kids.
- I remember being really depressed and feeling like giving up even when I was only 12 or 13.
- I totally exploded over little frustrations when I was a teenager.
- I kept doing so many stupid, goofy, unintentional mess-ups kids in my school thought I was pretty hopeless.
- I enjoyed aggravating my parents and teachers, and whenever I apologized, it was usually phony.
- I always felt awful about the grief I caused for my parents.
- I basically cheated my way through High School and (if applicable) College.
- Parents tried their best, but getting me to go to bed "on time" was hopeless.
- I took some incredible risks when I was a teenager!
- I was shy and insecure in relationships with other kids my age all the way through High School.
- I was really scared when it was time for me to learn how to drive on real highways and get a drivers license.
- I did not really have a "date" until way after most kids my age.
- I made one or more suicide attempts when I was a teenager.
- I started using drugs or alcohol by or before age 15.
- I had REALLY WILD, bizarre ideas when I was a teenager, ideas psychiatrists would call "crazy."
- I spent a lot of time in my room as a teenager, listening to depressing music, thinking morbid thoughts.

CURRENT SYMPTOMS:

SEVERITY – Using 0-5 scale as before.

- Every few months, sometimes only once or twice a year, I get incredibly down, depressed and feel like “giving up.”
- Every so often, I am incredibly driven, totally embroiled in some new project!
- I am on a chronic slow-boil, always angry, irritated, defensive and tense.
- I am usually anxious, fearful, and worried.
- I am persistently impatient with my spouse and kids.
- I am good at work, until it comes to paperwork! That drives me crazy!
- I use various kinds of substances to escape from reality.
- I place a high value on social conformity.
- I place a high value on spiritual values.
- I have high and low moods every day, sometimes every hour.
- Family members, sometimes, have been really concerned I get “wound up” and over-involved in what they call “wild and crazy” ideas.
- Every so often, I have used or consumed far more alcohol than I usually do.
- I have gone out gambling and blown a lot more money than I could afford more than twice in my life.
- Despite knowing better, I have blown even more money on gambling recently.
- I have had episodes of exceptionally “driven” behavior and virtually no sleep lasting 3-5 days at a time.
- I have had years and years of persisting, recurrent depression, interrupted by 8-12 week periods of feeling “normal” or even exceptionally good.
- I have had episodes of remarkable Hypersexuality: Preoccupation with sex, unusually active, frequent, or vigorous sex; risky sexual behaviors; illicit sexual behaviors using unusually poor judgment; uncharacteristic sexual behaviors.

- I have had “Obsessions with” or “Compulsions to” spend money, including inability to restrain spending money despite inadequate funds to cover spending.
- I have had recurrent problems with overdue and unpaid bills, past due notices, liens, utilities are canceled or shut off, insurance canceled, nothing ever paid on time.
- Relatives and friends describe my situation as one of “hopeless” disorganization and chaos, as if I need a full-time maid, Butler, and Valet for daily functioning.
- My sense of “forgetfulness” has begun to alarm my family and friends.
- I am having difficulty readily recalling familiar names, words, telephone numbers, and directions.
- I have had recent suicidal thoughts.
- I find myself steadily withdrawing from contact with friends, family, and usual activities.
- I consider my current situation essentially “hopeless.”
- WOMEN ONLY:** Extremely severe PMS.