PREMIER PSYCHOLOGICAL SERVICES

CLINICIAL QUESTIONNAIRE

Personal Information

Name____ D.O.B_________ Gender_______ Today's Date_________________

Address:____ City:_________________State/Zip code:____________________

Home Phone:_______________________Work Phone:_________________ Email:___________________________________

Marital Status:_______________________ Ever divorced? ___Yes ___No If yes, when?__________________________

Do you have children?________________ If so, how many?____

Current Concerns:

1. What are you most concerned about that has led you to see us today?____

____

____

2. What symptoms are you experiencing that are causing you concern? How severe are they? Have you experienced these symptoms for a long time? When did they begin?____

____

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____

3. Are there any medical conditions of which you are aware that could explain these symptoms?________________________

____

____

4. Have any negative or positive events occurred within the past few months at home, work, school or socially that could be a source of stress? If so, please explain:____

____

____

____

5. What personal strengths do you possess that help you cope?____

____

III. Childhood and Adolescent Historical Information

Please describe any childhood diseases/illnesses/surgeries/injuries:_______________________________________

____

Indicate if you had any of the following difficulties during your childhood or adolescence (Please circle YES responses)

Hyperactivity	Low Self-Esteem
Problems with Attention	Overly Passive
Problems with Self-Control	Nervous
Problems with Learning in School	Worried
Aggressive Behavior	Disorganized
Started Fights	Forgetful
Bullied Others	Trouble Learning in School
Lying	Unmotivated in School
Stealing	Trouble with Reading
Unhappy	Trouble with Writing
Few friends	Trouble with Math

Further comments ____

____

IV. Health Information

Have you had any of the following health problems?

Hyperactivity	Head Injury
Allergies	Surgery
Asthma	Diabetes
Cardiac Problems	Hearing Problems
High Blood Pressure	Vision Problems
Seizure Disorder	Psychiatric Problems
Broken Bones	Previous Hospitalizations
Poisoning	Problems with Fertility

Further details/dates:____

____

____

Are you currently taking any medications? Please list, if yes:______________________________

____

List any other health difficulties you have now or have had in the past____________________________

____

____

Who is your current primary care physician?____

Are you being treated by any other health professionals? If yes, provide details_______________________

____

V. Educational Information

The highest grade completed:
___8th ___9th ___10th ___11th ___12th ___some college ___graduated college ___college +

If you attended post-secondary school (vocational technical school/undergraduate/graduate school please provide:

Name of School______________________________ Dates attended_______________________ Degree_______________
Name of School______________________________ Dates attended_______________________ Degree_______________
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Describe any problems you may have had in school:____
____
____
____

VI. Social History

Which of the following best describes you most of the time (Check all that apply)

___generally feel positive	___mood changes from happy to sad easily
___generally feel optimistic	___quick to anger
___confident in my abilities	___irritable
___cheerful and generally happy	___sad/depressed much of the time
___slow to anger	___afraid to take chances
___anxious, generally worried	___trouble making decisions

Do you have trouble making friends? ___yes ___no If yes, please provide details:______________________________

____

Do you have trouble controlling your anger? ___yes ___no If yes, please provide details:______________________________

____

VII. Employment History

Are you currently employed? ___yes ___no. If yes, give details:

Current Employer:__________________________
Current Occupation:_________________________
Length of time in your current job:_____________

Provide your previous employment history below (start with your next most recent job)

Dates:_________________________ Job title_____________________________ Reason left________________________

Dates:_________________________ Job title_____________________________ Reason left________________________

Dates:_________________________ Job title_____________________________ Reason left________________________

Dates:_________________________ Job title_____________________________ Reason left________________________

Dates:_________________________ Job title_____________________________ Reason left________________________

VIII Anxiety Symptoms Checklist

Check the box that best describes your mood behavior over the past two weeks:	No	Yes
I become intensely fearful in certain situations and experience several of the following symptoms: *palpitations or accelerated heart rate *sweating *trembling or shaking *sensations of shortness of breath or smothering *feeling of choking *chest pain or discomfort *nausea or abdominal distress *feeling dizzy or lightheaded or faint *feelings of unreality or of being detached from oneself *fear of losing control *fear of dying *numbness *chills or hot flashes	________	________
I become anxious about being in places or situations from which escape might be difficult (or Embarrassing) or in which help may not be available		
I have a persistent fear that is excessive or unreasonable that is triggered by the presence or anticipation of a specific object or situation (e.g., flying, heights, animals, receiving an injection)		
I have a persistent fear of being embarrassed in social situations		
Social situations almost always cause me to become anxious		
I try to avoid situations that cause me to be afraid		
I have recurrent thoughts or impulses that are inappropriate and cause me to become anxious or distressed.		
I perform repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., Praying, counting, repeating words silently) to prevent something negative from occurring		
I have experienced, witnessed, or was exposed to an event or events that involved actual or threatened death or serious injury or a threat of such and I have recurrent distressing recollections of the event that interfere with my thinking.		
I have experienced excessive anxiety and worry on more days than not for at least the past six months.		

IX. Mood Problems Checklist

Please check the box that best describes your mood and behavior over the past two weeks and also mark if this has been present for 2 years or more.

	Yes	No	Present 2+ years
I feel depressed most of the day, nearly every day	__	__	________
I have little interest in doing things or find little pleasure in the things I used to enjoy			
I have had a significant weight loss/gain (more than 5% in a month) or change in appetite (decrease or increase)			
I have trouble falling asleep or I sleep too much nearly every day			
I have trouble concentrating and making decisions daily			
I have recurrent thoughts of death, recurrent suicidal thoughts			
I feel worthless or guilty nearly everyday			
Lately, my self-esteem is very good and I feel as if I could do just about anything			
I have less need for sleep than I generally do			
I am more talkative than usual or feel pressure to keep talking			
My ideas change often and my thoughts are racing			
I have become very distractible			
I am more focused in accomplishing goals than I normally am			
I have become involved in pleasurable activities that have had negative consequences (e.g., unrestrained buying sprees, sexual indiscretions, or foolish business investments)			

We realized that we have focused largely on problems that you may be having. However, we are also quite interested in understanding your strengths, talents, skills and accomplishments. Please share with us some of your assets!_______________

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Anything else about you we should know?____

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Thank you!