

PERSONAL INFORMATION QUESTIONNAIRE - ADULTS

This information will be kept confidential and is intended to assist us in helping you.

Please answer all questions as accurately as possible. If you have any questions, please ask.

WHAT ARE YOU SEEKING HELP WITH? _____

HAS ANYTHING BEEN WORRYING OR BOTHERING YOU? YES NO

IF SO, WHAT KIND OF THINGS DO YOU FIND YOURSELF THINKING ABOUT? _____

WHAT KINDS OF FEELINGS, SITUATIONS, OR THOUGHTS DO YOU TRY TO AVOID? _____

HAVE YOU EVER SEEN A COUNSELOR OR OTHER MENTAL HEALTH WORKER? YES NO

HAVE YOU EVER HAD A "NERVOUS BREAKDOWN"? YES NO DON'T KNOW

WERE YOU EVER HOSPITALIZED FOR YOUR NERVES OR EMOTIONAL PROBLEMS? YES NO

DOES ANYONE IN YOUR FAMILY HAVE MENTAL HEALTH PROBLEMS? YES NO DON'T KNOW

HAVE YOU HAD ANY SUICIDAL THOUGHTS OR ATTEMPTS? YES NO

BACKGROUND INFORMATION

ARE YOU MARRIED OR IN ANOTHER LONG-TERM RELATIONSHIP? YES NO

WHAT OTHER FAMILY DO YOU HAVE CONTACT WITH? MOTHER FATHER SISTER(S)

BROTHER(S) GRANDFATHER(S) GRANDMOTHER(S) IN-LAW(S)

DO YOU HAVE DIFFICULTY KEEPING UP WITH YOUR RESPONSIBILITIES? YES NO

DO YOU HAVE ANY CURRENT HOBBIES OR INTERESTS? YES NO

IF "YES," WHAT ARE THESE? _____

BACKGROUND

WHAT IS (OR WAS) YOUR FATHER LIKE? _____

HOW DO (OR DID) YOU AND YOUR FATHER GET ALONG? GOOD SO-SO BAD

WHAT IS (OR WAS) YOUR MOTHER LIKE? _____

HOW DO (OR DID) YOU AND YOUR MOTHER GET ALONG? GOOD SO-SO BAD

R1C3/C5

HOW DO (OR DID) YOUR PARENTS GET ALONG? GOOD SO-SO BAD

DO YOU HAVE ANY BROTHERS OR SISTERS? YES NO

HOW DO (OR DID) YOU AND YOUR BROTHERS/SISTERS GET ALONG? GOOD SO-SO BAD

HOW WAS YOUR CHILDHOOD OVERALL, GOOD SO-SO BAD CAN'T REMEMBER

WERE YOU EVER ABUSED AS A CHILD? YES NO DON'T KNOW

HOW WAS YOUR HEALTH AS A CHILD? GOOD SO-SO POOR

WAS YOUR CHILDHOOD SOCIAL ACTIVITY, TOO LITTLE ABOUT RIGHT TOO MUCH

DID YOU GET INTO ANY TROUBLE AS A CHILD? YES NO

R1C3/C5

EDUCATION

DID YOU RECEIVE ANY AWARDS OR HONORS WHILE IN SCHOOL? YES NO

WHAT KIND OF GRADES DID YOU GET? ABOVE AVERAGE AVERAGE BELOW AVERAGE

WERE YOU IN SPORTS, BAND, CLUBS, ETC. WHEN YOU WERE IN SCHOOL? YES NO

IF "YES," WHAT WERE THESE? _____

DID YOU HAVE ANY PROBLEMS WITH LEARNING? YES NO

HOW DID YOU GET ALONG WITH YOUR CLASSMATES? GOOD SO-SO POOR

HOW DID YOU GET ALONG WITH YOUR TEACHERS? GOOD SO-SO POOR

WORK HISTORY (Complete all that apply)

ARE YOU WORKING NOW? NO YES, AS A _____

HOW LONG HAVE YOU BEEN AT THIS JOB? _____

HOW DO YOU LIKE YOUR JOB? ENJOY IT TOLERATE IT DISLIKE/HATE IT

HOW DO YOU USUALLY GET ALONG WITH YOUR BOSS/SUPERVISOR? GOOD FAIR POOR

HOW DO YOU USUALLY GET ALONG WITH YOUR CO-WORKERS? GOOD FAIR POOR

SOCIAL HISTORY

DO YOU HAVE ANYONE YOU CAN TALK TO ABOUT YOUR CONCERNS? YES NO

IS YOUR CURRENT SOCIAL ACTIVITY, TOO LITTLE ABOUT RIGHT TOO MUCH

HOW DO YOU USUALLY GET ALONG WITH OTHER PEOPLE? GOOD FAIR POOR

IS THERE ANYONE YOU WOULD LIKE TO SEE MORE OFTEN? YES NO

SPIRITUAL/RELIGIOUS INVOLVEMENT (S/R LEVEL 1, R4C4)

WERE YOU RAISED IN A SPIRITUAL OR RELIGIOUS TRADITION? NO YES

HOW MUCH IS SPIRITUALITY/RELIGION A STRENGTH OR COMFORT TO YOU? NONE A LITTLE A LOT

HAVE YOU EVER HAD A LIFE-CHANGING RELIGIOUS OR SPIRITUAL EXPERIENCE? NO YES

CURRENT HEALTH

HOW IS YOUR HEALTH NOW? VERY GOOD GOOD FAIR POOR VERY POOR

WHEN DID YOU LAST SEE A DOCTOR? _____ WEEKS/MONTHS/YEARS AGO (CIRCLE ONE)

WHAT MEDICINES DO YOU TAKE? _____

HAVE YOU EVER USED ANY RECREATIONAL DRUGS? NO YES

DO YOU DRINK ALCOHOL? NO YES (If "Yes," please answer the following:)

Have you ever tried to cut down on your drinking? NO YES

Have people annoyed you by criticizing your drinking? NO YES

Have you ever felt bad or guilty about your drinking? NO YES

Have you ever had a drink first thing in the morning to settle your nerves or to get rid of a hangover?

NO YES

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number

	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	
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, 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 overall?	0	1	2	3	4	
IX.	15. Problems with memory (learning new information) or	0	1	2	3	4	

Name: _____

Age: _____

Sex: Male Female

Date: _____

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...			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)
II.	3.	Been bothered by not being able to fall asleep or stay asleep, or by waking up too early?	0	1	2	3	4	
IV.	5.	Had less fun doing things than you used to?	0	1	2	3	4	
	6.	Felt sad or depressed for several hours?	0	1	2	3	4	
VII.	9.	Started lots more projects than usual or done more risky things than usual?	0	1	2	3	4	
	10.	Slept less than usual but still had a lot of energy?	0	1	2	3	4	
IX.	14.	Heard voices—when there was no one there—speaking about you or telling you what to do or saying bad things to you?	0	1	2	3	4	
	15.	Had visions when you were completely awake—that is, seen something or someone that no one else could see?	0	1	2	3	4	
In the past TWO (2) WEEKS , have you...								
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	<input type="checkbox"/> Yes		<input type="checkbox"/> No			
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	<input type="checkbox"/> Yes		<input type="checkbox"/> No			
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like Ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	<input type="checkbox"/> Yes		<input type="checkbox"/> No			
	23.	Used any medicine without a doctor's prescription to get high or change the way you feel (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	<input type="checkbox"/> Yes		<input type="checkbox"/> No			