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

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 ☐ ALOT

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

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	