CLINICAL HISTORY FORM FOR PATIENTS

AND FAMILIES

Please complete this form to the best of your ability. If you are doing this on behalf of a minor or spouse, please indicate this. Your responses will be kept confidential unless specifically released by you to another agency.

Name of Patient: _____ Birth Date: _____

Address: _____

_____

Telephone Number Including Area Code: _____

Name of Person Completing Form: _____

I. CURRENT HISTORY

Please describe in your own words the reason why you are seeking consultation with me currently:

In the space below, describe as succinctly as possible the history of this problem. Include in your description how the problem began, how often you are experiencing symptoms, how do the symptoms interfere with your life, your work, your education, and your relationship with those important to you?

Do you have any difficulty falling asleep, staying asleep, or maintaining alertness through the day? If so, please describe.

Do you have any difficulty with appetite?

Do you have any difficulty with sexual energy (patients over age eighteen)?

Have you ever had episodes of violence where you have destroyed property?

Have you ever had episodes of violence where you have hurt another person?

Have you ever felt like hurting another person. If so, please describe.

Have you ever felt like hurting yourself? If so, please describe.

Have you ever made any actual attempts on your own life?

Have you ever been hospitalized for a psychiatric disorder?

Please list the important people in your life currently.

Have you ever been the victim of physical or sexual abuse?

Have you ever been the victim of emotional abuse?

II. MEDICAL HISTORY

Do you have any medical problems currently that require physician supervision?

Please list any medications that you are currently taking.

Have you ever had a seizure disorder, a head injury, or have you ever been rendered unconscious? If so, please describe.

Have you ever suffered from an eating disorder? If so, please describe.

III. FAMILY HISTORY

Has anyone in your family suffered from a psychiatric illness?

As anyone in your family suffered from alcoholism or drug dependency?

IV. SUBSTANCE ABUSE HISTORY

Do you use alcohol? If so, how do you use alcohol?

Do you use street drugs? If so how do you use them?

How many times during the past year have you been intoxicated from the effects of alcohol?

How many times during the past year have you been intoxicated from the effects of street drugs?

V. SOCIAL HISTORY

Have you ever had difficulty with the law?

Have you ever been suspended from school?

How far have you gone in school?

Please describe the quality of your school experience.

VI. COMMENTS

What do you find positive about yourself?

What do you find positive about your life?

Any other items that you wish to add to this inventory.

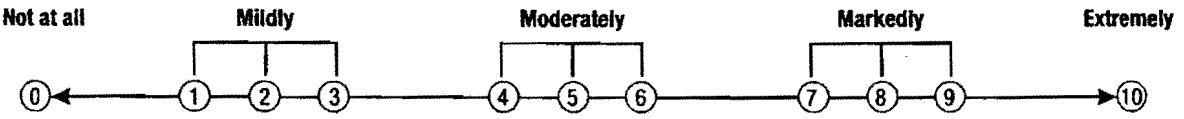
SHEEHAN DISABILITY SCALE

A BRIEF, PATIENT RATED MEASURE OF DISABILITY AND IMPAIRMENT

Please mark ONE circle for each scale.

WORK* / SCHOOL

The symptoms have disrupted your work / school work:

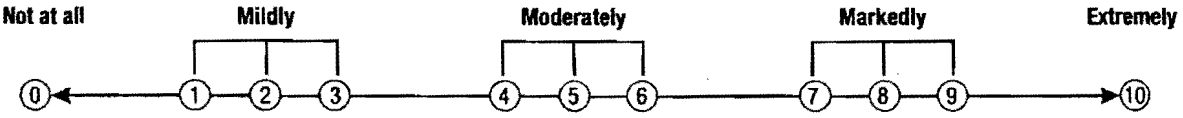


☐ I have not worked / studied at all during the past week for reasons unrelated to the disorder.

**Work includes paid, unpaid volunteer work or training*

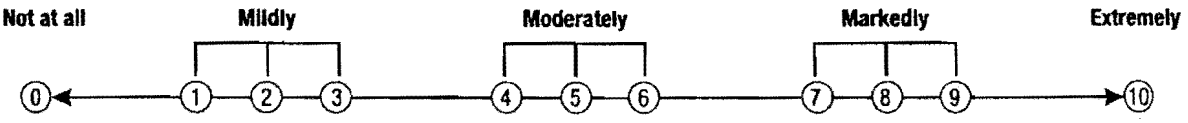
SOCIAL LIFE

The symptoms have disrupted your social life / leisure activities:



FAMILY LIFE / HOME RESPONSIBILITIES

The symptoms have disrupted your family life / home responsibilities:



DAYS LOST

On how many days in the last week did your symptoms cause you to miss school or work or leave you unable to carry out your normal daily responsibilities? _____

DAYS UNDERPRODUCTIVE

On how many days in the last week did you feel so impaired by your symptoms, that even though you went to school or work, your productivity was reduced? _____

Name_____ **Date** _____

SHEEHAN PATIENT RATED ANXIETY SCALE

During the past week, how much did you suffer from ...
(Check only one answer for each question)

	Not at All	A Little	Moderately	Quite a Bit	Extremely
1. Difficulty in getting your breath, smothering, or overbreathing	❑	❑	❑	❑	❑
2. Choking sensation or lump in throat	❑	❑	❑	❑	❑
3. Skipping, racing, or pounding of your heart	❑	❑	❑	❑	❑
4. Chest pain, pressure, or discomfort	❑	❑	❑	❑	❑
5. Bouts of excessive sweating	❑	❑	❑	❑	❑
6. Faintness, light-headedness, or dizzy spells	❑	❑	❑	❑	❑
7. Sensation of rubbery or "jelly" legs	❑	❑	❑	❑	❑
8. Feeling off balance or unsteady like you might fall	❑	❑	❑	❑	❑
9. Nausea or stomach problems	❑	❑	❑	❑	❑
10. Feeling that things around you are strange, unreal, foggy, or detached from you	❑	❑	❑	❑	❑
11. Feeling outside or detached from part or all of your body, or a floating feeling	❑	❑	❑	❑	❑
12. Tingling or numbness in pans of your body	❑	❑	❑	❑	❑
13. Hot flashes or cold chills	❑	❑	❑	❑	❑
14. Shaking or trembling	❑	❑	❑	❑	❑
15. Having a fear that you are dying or that something terrible is about to happen	❑	❑	❑	❑	❑
16. Feeling you are losing control or going insane	❑	❑	❑	❑	❑
17. Sudden anxiety attacks with three or more of the symptoms (listed above) that occur when you are in or about to go into a situation that is likely, from your experience, to bring on an attack	❑	❑	❑	❑	❑
18. Sudden unexpected anxiety attacks with three or more symptoms (listed above) that occur with little or no provocation (i.e., when you are NOT in a situation that is likely, from your experience, to bring on an attack)	❑	❑	❑	❑	❑

	Not at All	A Little	Moderately	Quite a Bit	Extremely
19. Sudden unexpected spells with only one or two symptoms (listed above) that occur with little or no provocation (i.e., when you are NOT in a situation that is likely, from your experience, to bring on an attack)	❑	❑	❑	❑	❑
20. Anxiety episodes that build up as you anticipate doing something that is likely, from your experience, to bring on anxiety that is more intense than most people experience in such situations	❑	❑	❑	❑	❑
21. Avoiding situations because they frighten you	❑	❑	❑	❑	❑
22. Being dependent on others	❑	❑	❑	❑	❑
23. Tension and inability to relax	❑	❑	❑	❑	❑
24. Anxiety, nervousness, restlessness	❑	❑	❑	❑	❑
25. Spells of increased sensitivity to sound, light, or touch	❑	❑	❑	❑	❑
26. Attacks of diarrhea	❑	❑	❑	❑	❑
27. Worrying about your health too much	❑	❑	❑	❑	❑
28. Feeling tired, weak, and exhausted easily	❑	❑	❑	❑	❑
29. Headaches or pains in neck or head	❑	❑	❑	❑	❑
30. Difficulty in falling asleep	❑	❑	❑	❑	❑
31. Waking in the middle of the night, or restless sleep	❑	❑	❑	❑	❑
32. Unexpected waves of depression occurring with little or no provocation	❑	❑	❑	❑	❑
33. Emotions and moods going up and down a lot in response to changes around you	❑	❑	❑	❑	❑
34. Recurrent and persistent ideas, thoughts, impulses, or images that are intrusive, unwanted, senseless, or repugnant.	❑	❑	❑	❑	❑
35. Having to repeat the same action in a ritual, e.g. checking, washing, counting repeatedly, when it's not really necessary	❑	❑	❑	❑	❑

Beck's Depression Inventory

This depression inventory can be self-scored. The scoring scale is at the end of the questionnaire.

1.
- 0 I do not feel sad.
- 1 I feel sad
- 2 I am sad all the time and I can't snap out of it.
- 3 I am so sad and unhappy that I can't stand it.

2.
- 0 I am not particularly discouraged about the future.
- 1 I feel discouraged about the future.
- 2 I feel I have nothing to look forward to.
- 3 I feel the future is hopeless and that things cannot improve.

3.
- 0 I do not feel like a failure.
- 1 I feel I have failed more than the average person.
- 2 As I look back on my life, all I can see is a lot of failures.
- 3 I feel I am a complete failure as a person.

4.
- 0 I get as much satisfaction out of things as I used to.
- 1 I don't enjoy things the way I used to.
- 2 I don't get real satisfaction out of anything anymore.
- 3 I am dissatisfied or bored with everything.

5.
- 0 I don't feel particularly guilty
- 1 I feel guilty a good part of the time.
- 2 I feel quite guilty most of the time.
- 3 I feel guilty all of the time.

6.
- 0 I don't feel I am being punished.
- 1 I feel I may be punished.
- 2 I expect to be punished.
- 3 I feel I am being punished.

7.
- 0 I don't feel disappointed in myself.
- 1 I am disappointed in myself.
- 2 I am disgusted with myself.
- 3 I hate myself.

8.
- 0 I don't feel I am any worse than anybody else.
- 1 I am critical of myself for my weaknesses or mistakes.
- 2 I blame myself all the time for my faults.
- 3 I blame myself for everything bad that happens.

9.
- 0 I don't have any thoughts of killing myself.
- 1 I have thoughts of killing myself, but I would not carry them out.
- 2 I would like to kill myself.
- 3 I would kill myself if I had the chance.

10.
- 0 I don't cry any more than usual.
- 1 I cry more now than I used to.
- 2 I cry all the time now.
- 3 I used to be able to cry, but now I can't cry even though I want to.

11.

0 I am no more irritated by things than I ever was.
1 I am slightly more irritated now than usual.
2 I am quite annoyed or irritated a good deal of the time.
3 I feel irritated all the time.

12.

0 I have not lost interest in other people.
1 I am less interested in other people than I used to be.
2 I have lost most of my interest in other people.
3 I have lost all of my interest in other people.

13.

0 I make decisions about as well as I ever could.
1 I put off making decisions more than I used to.
2 I have greater difficulty in making decisions more than I used to.
3 I can't make decisions at all anymore.

14.

0 I don't feel that I look any worse than I used to.
1 I am worried that I am looking old or unattractive.
2 I feel there are permanent changes in my appearance that make me look unattractive
3 I believe that I look ugly.

15.

0 I can work about as well as before.
1 It takes an extra effort to get started at doing something.
2 I have to push myself very hard to do anything.
3 I can't do any work at all.

16.

0 I can sleep as well as usual.
1 I don't sleep as well as I used to.
2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
3 I wake up several hours earlier than I used to and cannot get back to sleep.

17.

0 I don't get more tired than usual.
1 I get tired more easily than I used to.
2 I get tired from doing almost anything.
3 I am too tired to do anything.

18.

0 My appetite is no worse than usual.
1 My appetite is not as good as it used to be.
2 My appetite is much worse now.
3 I have no appetite at all anymore.

19.

0 I haven't lost much weight, if any, lately.
1 I have lost more than five pounds.
2 I have lost more than ten pounds.
3 I have lost more than fifteen pounds.

20.

0 I am no more worried about my health than usual.
1 I am worried about physical problems like aches, pains, upset stomach, or constipation.
2 I am very worried about physical problems and it's hard to think of much else.
3 I am so worried about my physical problems that I cannot think of anything else.

21.

0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I have almost no interest in sex.
3 I have lost interest in sex completely.

INTERPRETING THE BECK DEPRESSION INVENTORY

Now that you have completed the questionnaire, add up the score for each of the twenty-one questions by counting the number to the right of each question you marked. The highest possible total for the whole test would be sixty-three. This would mean you circled number three on all twenty-one questions. Since the lowest possible score for each question is zero, the lowest possible score for the test would be zero. This would mean you circles zero on each question. You can evaluate your depression according to the Table below.

Total Score	Levels of Depression
1-10	These ups and downs are considered normal
11-16	Mild mood disturbance
17-20	Borderline clinical depression
21-30	Moderate depression
31-40	Severe depression
over 40	Extreme depression

A PERSISTENT SCORE OF 17 OR ABOVE INDICATES THAT YOU MAY NEED MEDICAL TREATMENT. IF YOU HAVE ANY CARDIAC CONCERNS, PLEASE CONTACT CARDIOVASCULAR INTERVENTIONS, P.A. at 407-894-4880

Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

Patient Name		Today's Date	

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.	Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?					
3. How often do you have problems remembering appointments or obligations?					
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?					

Part A

7. How often do you make careless mistakes when you have to work on a boring or difficult project?					
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
10. How often do you misplace or have difficulty finding things at home or at work?					
11. How often are you distracted by activity or noise around you?					
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?					
13. How often do you feel restless or fidgety?					
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?					
15. How often do you find yourself talking too much when you are in social situations?					
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?					
17. How often do you have difficulty waiting your turn in situations when turn taking is required?					
18. How often do you interrupt others when they are busy?					

Part B