Salisbury Psychiatric Associates, PC

427 West Innes Street • Salisbury, North Carolina 28144

NAME: ____ DATE ____________

INSTRUCTIONS: Listed below are some symptoms or problems that people sometimes have. Please read each one carefully and decide how much the symptoms bothered or distressed you **in the past month** including today.

Decide how much the symptom affected you. NOT AT ALL? A LITTLE? MODERATELY? QUITE A BIT? EXTREMELY? and place a check in the appropriate column to the right.

HOW MUCH WERE YOU BOTHERED BY THE FOLLOWING SYMPTOMS? (Do not leave out any Items)

SYMPTOMS	Not at all 0	A Little Bit 1	Mod-erate-ly 2	Quite a bit 3	Ex-treme-ly 4	SYMPTOMS	Not at all 0	A Little Bit 1	Mod-erate-ly 2	Quite a bit 3	Ex-treme-ly 4
1. Headaches						21. Feeling shy or uneasy with the opposite sex					
2. Nervousness or shakiness inside						22. Feeling of being trapped or caught					
3. Unwanted thoughts, words or ideas that won't leave your mind						23. Suddenly scared for no reason					
4. Faintness or dizziness						24. Temper outbursts that you could not control					
5. Loss of sexual interest or pleasure						25. Feeling afraid to go out of your house alone					
6. Feeling critical of others						26. Blaming yourself for things					
7. The idea that someone else can control your thoughts						27. Pains in lower back					
8. Feeling others are to blame for most of your troubles						28. Feeling blocked in getting things done					
9. Trouble remembering things						29. Feeling lonely					
10. Worried about sloppiness or carelessness						30. Feeling blue					
11. Feeling easily annoyed or irritated						31. Worrying too much about things					
12. Pains in heart or chest						32. Feeling no interest in things					
13. Feeling afraid in open spaces or on the streets						33. Feeling fearful					
14. Feeling low in energy or slowed down						34. Your feelings being easily hurt					
15. Thoughts of ending your life						35. Other people being aware of your private thoughts					
16. Hearing voices that other people do not hear						36. Feeling that people are unfriendly or dislike you					
17. Trembling						37. Having to do things very slowly to insure correctness					
18. Feeling that most people cannot be trusted						38. Heart pounding or racing					
19. Poor Appetite						39. Nausea or upset stomach					
20. Crying easily						40. Feeling inferior to others					

Salisbury Psychiatric Associates, PC

HOW MUCH WERE YOU BOTHERED BY THE FOLLOWING SYMPTOMS? (Do not leave out any items)

SYMPTOMS	Not at all 0	A Little Bit 1	Moderately 2	Quite a bit 3	Extremely 4
41. Soreness of your muscles					
42. Feeling that you are watched or talked about by others					
43. Trouble falling asleep					
44. Having to check and double-check what to do					
45. Difficulty making decisions					
46. Feeling afraid to travel on buses, subways or trains					
47. Trouble getting your breath					
48. Hot or cold spells					
49. Having to avoid certain things, places or activities because they frighten you					
50. Your mind going blank					
51. Numbness or tingling in parts of your body					
52. A lump in your throat					
53. Feeling hopeless about the future					
54. Trouble concentrating					
55. Feeling weak in parts of your body					
56. Feeling tense or keyed up					
57. Heavy feeling in your arms or legs					
58. Thoughts of death or dying					
59. Overeating					
60. Feeling uneasy when people are watching or talking about you					
61. Having thoughts that are not your own					
62. Having urges to beat or harm someone					
63. Awakening in the early morning					
64. Having to repeat the same actions such as touching, counting, washing					
65. Sleep that is restless or disturbed					

SYMPTOMS	Not at all 0	A Little Bit 1	Moderately 2	Quite a bit 3	Extremely 4
66. Having urges to break or smash things					
67. Having ideas or beliefs that others do not share					
68. Feeling very self-conscious with others					
69. Feeling uneasy in crowds, such as shopping or at a movie					
70. Feeling everything is an effort					
71. Spells of terror or panic					
72. Feeling uncomfortable about eating or drinking in public					
73. Getting into frequent arguments					
74. Feeling nervous when you are left alone					
75. Others not giving you proper credit for your achievements					
76. Feeling lonely even when you are with people					
77. Feeling so restless you couldn't sit still					
78. Feelings of worthlessness					
79. Feeling that familiar things are strange or unreal					
80.Shouting or throwing things					
81. Feeling afraid you will faint in public					
82. Feeling that people will take advantage of you if you let them					
83. Having thoughts about sex that bother you a lot					
84. The idea that you should be punished for your sins					
85. Feeling pushed to get things done					
86. The idea that something serious is wrong with your body					
87. Never feeling close to another person					
88. Feeling of guilt					
89. The idea that something is wrong with your mind					

Salisbury Psychiatric Associates, PC

MEDICAL HISTORY SELF REPORT

DATE ______

THIS FORM WILL BE TREATED AS PART OF YOUR MEDICAL RECORD. PLEASE ASK ABOUT ANY ITEMS YOU DO NOT UNDERSTAND.

NAME ______ SS# ______ TELEPHONE ______
ADDRESS ______ CITY ______ STATE ______ ZIP ______
DATE OF BIRTH ______ AGE ____ SEX ____ WEIGHT ____ HEIGHT ______
OCCUPATION ______ YEARS OF EDUCATION ______

PRESENTING PROBLEM (Include the duration of present symptoms, precipitating events and resemblance to past conditions)

______
______
______
______

FAMILY CONSTELLATION (Persons living at home)

Name	Relationship	Age

FAMILY PHYSICIAN ______ ADDRESS ______
PERSON WHO REFERRED YOU HERE ______
PERSON TO NOTIFY
IN CASE OF EMERGENCY ______ TELEPHONE ______

PAST MEDICAL HISTORY (Please check any illnesses that you currently have or have had in the past)

____ Diabetes
____ Rheumatic Fever
____ Arthritis
____ Thyroid Disease
____ Anemia
____ Ulcer
____ Nerve Disorder
____ High Blood Pressure
____ Low Blood Pressure
____ Heart Disease
____ Pneumonia
____ TB
____ Colitis
____ Seizures
____ Lung Disease
____ Cancer
____ Jaundice
____ Hepatitis
____ Cirrhosis
____ Bone Disorder
____ Other ______ (Please describe)
____ Venereal Disease (Syphilis/Gonorrhea)
____ Kidney Disorder
____ Head Injuries
____ Injuries
____ Muscular Disorder

FAMILY MEDICAL HISTORY: Please list any blood relatives (parents, brothers, sisters, uncles, aunts, cousins, grandparents or children) that have had any of the above illnesses.

Relative	Disease	Relative	Disease

MEDICAL HISTORY SELF REPORT

PAST SURGERY (Include any major surgical procedures)

Date	Type of Surgery	Hospital	Doctor

PAST HOSPITALIZATION (Include psychiatric hospitalizations)

Date	Reason	Hospital	Doctor

MEDICATION (List ALL prescription and non-prescription drugs you are currently taking)

Medication	Dosage	Reason	Results				
			V. Good	Good	Fair	Poor	Adverse Reaction

DRUG SENSITIVITIES AND TYPES OF REACTION ______________________________

____

____

____

ALLERGIES: ______________________________

____

____

____

MEDICAL HISTORY
SELF REPORT

HABITS:

Estimated daily consumption of coffee, cola or tea ____________ cups/day.
Estimated daily consumption of tobacco _______________packs/day.
Estimated daily consumption of alcohol ____
Type and frequency of drug usage ____

PRIOR OUTPATIENT TREATMENT FOR EMOTIONAL PROBLEMS OR NERVOUS DISORDERS

Date ___________________
Problem _________________________________ Treatment ______________________________
Provider _________________________________ Results ______________________________

Date ___________________
Problem _________________________________Treatment ______________________________
Provider _________________________________ Results ______________________________

FAMILY PSYCHIATRIC HISTORY

Has anyone related to you ever been a patient in a mental hospital or ever had trouble with nervousness, extreme excitement, depression, nervous breakdowns, drug abuse or heavy drinking? If yes, please list below his/her relationship to you and their symptoms. Also, include medications they were taking for their problems, if known.

Relationship	Symptoms/Problems	Medication

Have you, or anyone related to you, ever attempted suicide? __________Yes __________No
If yes, please list the relationship ____
Have you, or anyone related to you, ever attempted or committed a homicide?____Yes ___No
If yes, please list the relationship ____
Additional comments: ____

MEDICAL HISTORY
SELF REPORT

PLEASE CHECK ALL ITEMS THAT APPLY TO YOU DURING THE PAST MONTH:

HEAD and NECK
- ___ frequent headache
- ___ neck pains
- ___ neck lumps or swelling
- ___ trouble swallowing

EYES
- ___ wear glasses
- ___ blurry vision
- ___ eyesight worsening
- ___ sees double
- ___ eye pain or itching
- ___ watering eyes
- ___ eye trouble

EARS
- ___ hears voices (that are not real)
- ___ hears noises (that are not real)
- ___ hearing difficulty
- ___ earaches
- ___ runny ears
- ___ buzzing in ears
- ___ ringing in ears
- ___ motion sickness

MOUTH
- ___ dental problems
- ___ swelling of gums or jaws
- ___ sore tongue
- ___ taste changes

NOSE and THROAT
- ___ smell odors (that are not real)
- ___ congested nose
- ___ runny nose
- ___ sneezing spells
- ___ head colds
- ___ nose bleeds
- ___ sore throat
- ___ enlarged tonsils
- ___ hoarse voice

RESPIRATORY
- ___ sometimes breathes too fast
- ___ sneezes
- ___ shortness of breath
- ___ coughing spells
- ___ cough up phlegm
- ___ cough up blood
- ___ chest colds
- ___ excessive sweating
- ___ night sweats

NEUROLOGICAL
- ___ faintness
- ___ numbness
- ___ tingling
- ___ convulsions
- ___ change in handwriting
- ___ clumsiness
- ___ loss of strength
- ___ difficulty controlling anger
- ___ paralysis

NEUROLOGICAL (CONT.)
- ___ memory trouble
- ___ trouble thinking
- ___ thoughts racing too fast
- ___ recurrent unpleasant thoughts
- ___ head injury (date ___________)
- ___ knocked unconscious
- ___ confused following drug intake

CARDIOVASCULAR
- ___ high blood pressure
- ___ racing heart
- ___ chest pains
- ___ need more pillows to breathe better
- ___ swollen feet or ankles
- ___ leg cramps
- ___ heart murmur

DIGESTIVE
- ___ heart burn
- ___ belching
- ___ indigestion
- ___ stomach pains
- ___ nausea
- ___ vomit blood
- ___ small stools
- ___ constipation
- ___ loose stools
- ___ grey stools
- ___ black stools
- ___ pain in rectum
- ___ rectum bleeding

URINARY
- ___ night frequency
- ___ day frequency
- ___ wet pants or bed
- ___ burning on urination
- ___ brown, black or bloody urine
- ___ difficulty starting urine

MALE GENITAL
- ___ weak urine stream
- ___ prostrate trouble
- ___ impotence
- ___ burning or discharge
- ___ lumps on testicles
- ___ painful testicles

MUSCULOSKELETAL
- ___ aching muscles
- ___ aching joints
- ___ swollen joints
- ___ back pain
- ___ painful feet

SKIN
- ___ dry skin
- ___ skin rash

Patient's signature ___________________________
(only indicates the above has been read and any terms not understood will be brought up with the doctor).

SKIN (CONT.)
- ___ itching or burning skin
- ___ bleed easily
- ___ bruise easily
- ___ change in color

FEMALE GENITAL
- ___ menstrual trouble
- ___ breakthrough bleeding
- ___ irregular cycles
- ___ heavy bleeding
- ___ bleeding after intercourse
- ___ pain during intercourse
- ___ premenstrual tension
- ___ hot flashes
- ___ birth control pills
- ___ lumps in breast
- ___ vaginal discharge
- ___ PAP smear (date) _________
- ___ last period (date) _________
- ___ method of contraception______

PREGNANCIES
- ___ pregnancies # _______
- ___ miscarriages # _______
- ___ stillbirths # _______
- ___ premature births # ______
- ___ deliveries # ______
- ___ cesareans # ______
- ___ abortions # ______

GENERAL
- ___ weight gain ________#
- ___ weight loss ________#
- ___ tend to be too hot
- ___ tend to be too cold
- ___ loss of interest in eating
- ___ always hungry
- ___ more thirsty lately
- ___ armpits or groin swelling
- ___ fatigue
- ___ smoke tobacco
- ___ drinks alcohol daily
- ___ heavy coffee or tea drinker
- ___ marijuana
- ___ LSD, other hallucinogens
- ___ heroin, barbituates, PCP, amphetamines, etc.
- ___ bite fingernails
- ___ trouble falling asleep
- ___ trouble staying asleep
- ___ sleep too much
- ___ wake up earlier than usual
- ___ feel best in morning
- ___ feel best at night
- ___ restlessness
- ___ poor dietary habits
- ___ decreased interest in sex