Salisbury Psychiatric Associates, PC

427 West Innes Street • Salisbury, North Carolina 28144

NAME:	DATE
INSTRUCTIONS: Listed below are some sym	ptoms or problems that people sometimes have.
Please read each one carefully and decide how muc	ch 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	A Little Bit	Mod- erate- ly 2	Quite a bit	Ex- treme ly	SYMPTOMS	Not at all	A Little Bit	Mod- erate- ly 2	Quite a bit	Ex- treme- ly 4
1. Headaches	J					21. Feeling shy or uneasy with the opposite sex		<u> </u>		<u></u>	
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					
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					

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

SYMPTOMS		A Little Bit	Mod- erate- ly	a bit	Ex- treme- ly	SYMPTOMS		A Little Bit	Mod- erate- ly	abit	Ex- treme ly
41. Soreness of your muscles	0	1	2	3	4_	66. Having urges to break or smash things	0.	1.	2	3	4
42. Feeling that you are watched or talked about by others				:		67. Having ideas or beliefs that others do not share					
43. Trouble falling asleep						68. Feeling very self-conscious with others					
44. Having to check and double-check what to do						69. Feeling uneasy in crowds, such as shopping or at a movie					
45. Difficulty making decisions						70. Feeling everything is an effort		·		,	
46. Feeling afraid to travel on buses, subways or trains						71. Spells of terror or panic			•		
47. Trouble getting your breath						72. Feeling uncomfortable about eating or drinking in public					
48. Hot or cold spells						73. Getting into frequent arguments					
49. Having to avoid certain things, places or activities because they frighten you						74. Feeling nervous when you are left alone					
50. Your mind going blank						75. Others not giving you proper credit for your achievements					
51. Numbness or tingling in parts of your body						76. Feeling lonely even when you are with people					
52. A lump in your throat						77. Feeling so restless you couldn't sit still					
53. Feeling hopeless about the future						78. Feelings of worthlessness					
54. Trouble concentrating						79. Feeling that familiar things are strange or unreal		·		:	
55. Feeling weak in parts of your body						80.Shouting or throwing things					
56. Feeling tense or keyed up						81. Feeling afraid you will faint in public					
57. Heavy feeling in your arms or legs						82. Feeling that people will take advantage of you if you let them					
58. Thoughts of death or dying						83. Having thoughts about sex that bother you a lot					
59. Overeating						84. The idea that you should be punished for your sins					
60. Feeling uneasy when people are watching or talking about you						85. Feeling pushed to get things done					
61. Having thoughts that are not your own						86. The idea that something serious is wrong with your body					
62. Having urges to beat or harm someone						87. Never feeling close to another person					
63. Awakening in the early morning						88. Feeling of guilt					
64. Having to repeat the same actions such as touching, counting, washing						89. The idea that something is wrong with your mind				-	
65. Sleep that is restless or disturbed									-		

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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 ______STATE ____ ZIP ____ DATE OF BIRTH _____ AGE ___ SEX ___ WEIGHT ____ HEIGHT ____ YEARS OF EDUCATION _____ OCCUPATION 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 _____ 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 ____ High Blood Pressure ____ Lung Disease ____ Venereal Disease Rheumatic Fever ____ Low Blood Pressure ____ Cancer (Syphilis/Gonorrhea) ____ Arthritis ____ Heart Disease ____ Jaundice ____ Kidney Disorder ____ Thyroid Disease ____ Pneumonia ____ Hepatitis ____ Cirrhosis ____ Head Injuries __ Anemia ____ TB ____ Injuries ___ Bone Disorder Ulcer ____ Colitis ____ Muscular Disorder ____ Nerve Disorder ____ Seizures ____ Other ____ (Please describe) 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

Date	Type of St	surgical procedures) urgery	Hospital			Doct	or
PAST HOSPITALIZA Date	TION (Include ps Reason	sychiatric hospitalizatio	ns) Hospital			Doct	or
MEDICATION (List A	LL prescription a Dosage	nd non-prescription dr	ugs you are cu V. Good	F	lesults		Adverse Reaction
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ORUG SENSITIVITIE	ES AND TYPES (OF REACTION	·				
ALLERGIES:							

MEDICAL HISTORY SELF REPORT

TS:		
Estimated daily co	consumption of coffee, cola or tea cups/day.	
Estimated daily co	consumption of tobaccopacks/day.	
Estimated daily co	consumption of alcohol	
Type and frequen	ncy of drug usage	
R OUTPATIENT T	BEATMENT FOR EMOTIONAL PROBLEMS OF NEDVOUS	DISOBNEDS
		DISOUDERS
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Date		
Provider	Results	
nervousness, extr drinking? If yes, pl medications they	reme excitement, depression, nervous breakdowns, drug abus please list below his/her relationship to you and their symptoms were taking for their problems, if known.	e or heavy
·		
Have you, or anyo	one related to you, ever attempted suicide?Yes the relationship	No
Have you, or anyo	one related to you, ever attempted or committed a homicide?_	YesNo
If yes, please list the	the relationship	
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MEDICAL HISTORY SELF REPORT

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

frequent headache neck pains neck lumps or swelling trouble thinking neck lumps or swelling trouble swallowing color fectors and plury (date	HEAD and NECK	NEUROLOGICAL (CONT.)	SKIN (CONT.)
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