

What vitamins, supplements, or over the counter products are you taking?

6. Please check any of the following conditions that have applied to you over the past 6 months:

- | | | |
|---|---|---|
| <input type="checkbox"/> Delay in falling asleep | <input type="checkbox"/> Feeling irritable | Physical symptoms:
<input type="checkbox"/> Back pain
<input type="checkbox"/> Headaches
<input type="checkbox"/> Dizziness
<input type="checkbox"/> Digestive problems
<input type="checkbox"/> Rapid heart beat/pounding heart
<input type="checkbox"/> Stomach pain
<input type="checkbox"/> Chest pain
<input type="checkbox"/> Shortness of breath
<input type="checkbox"/> Constipation or diarrhea
<input type="checkbox"/> Nausea or vomiting
<input type="checkbox"/> Other Digestive problems
<input type="checkbox"/> Fainting spells
<input type="checkbox"/> Pain in arms, legs, joints
<input type="checkbox"/> Pain during sexual intercourse
<input type="checkbox"/> History of traumatic events
<input type="checkbox"/> Other: _____
_____ |
| <input type="checkbox"/> Awakening during the night | <input type="checkbox"/> Feeling angry | |
| <input type="checkbox"/> Oversleeping/napping | <input type="checkbox"/> Trouble concentrating/paying attention | |
| <input type="checkbox"/> Loss of energy, feeling tired | <input type="checkbox"/> People are following me | |
| <input type="checkbox"/> Moving of speaking so slowly that others notice, or the opposite | <input type="checkbox"/> People are watching me | |
| <input type="checkbox"/> Changes in appetite | <input type="checkbox"/> Mood swings | |
| <input type="checkbox"/> Weight loss or gain | <input type="checkbox"/> Hearing voices | |
| <input type="checkbox"/> Agitation | <input type="checkbox"/> Feeling tense | |
| <input type="checkbox"/> Sad or depressed mood | <input type="checkbox"/> Sexual problems | |
| <input type="checkbox"/> Feelings of hopelessness | <input type="checkbox"/> Financial problems | |
| <input type="checkbox"/> Feelings of guilt | <input type="checkbox"/> Relationship problems | |
| <input type="checkbox"/> Crying spells | <input type="checkbox"/> Substance abuse in family | |
| <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Worrying/Anxiety | |
| <input type="checkbox"/> Obsessive thoughts/actions | <input type="checkbox"/> Restless, keyed up, on edge | |
| <input type="checkbox"/> Decreased interest or pleasure in doing things | <input type="checkbox"/> Fears | |
| <input type="checkbox"/> Feeling like a failure | <input type="checkbox"/> Anxiety/Panic attacks | |

7. Are you having thoughts of wanting to be dead, or thoughts that you would be better off dead yes no
- Are you having thoughts of wanting to harm yourself? yes no
- If yes, intensity of thoughts is: mild moderate severe
- If yes, Do you have a plan or intend to harm your self? yes no
- Have you ever attempted suicide? yes no
- If yes, when? _____

Are you having thoughts of wanting to cause harm to another person? yes no

8. Have you ever been a victim of: physical abuse sexual abuse emotional abuse

9. Are you in a relationship in which you have been hurt or threatened? yes no

Legal issues due to domestic violence for you or partner? yes no

10. Do you think you might have a problem with alcohol or drugs? yes no possibly

11. When did you last get drunk or high on drugs? _____

12. Have you ever had any legal problems due to alcohol/drug use (i.e. D.U.I., D.W.I.)? Yes No
If yes, what and when: _____

Check Yes or No:

Have you ever felt the need to cut down on your drinking or drugging? yes no

Have you ever been annoyed by someone criticizing your drinking or drugging? yes no

Have you ever felt guilty about your drinking? yes no

Have you ever had a drink first thing in the morning to steady your nerves or for a hangover (eye-opener)? yes no

Do you think you have a current problem with drugs or alcohol? yes no

Do you have a past history of an alcohol or drug problem? yes no

13. During the last 6 months how frequently have you used the following? (Please check all that apply):

	Daily	Weekly	2 or more weekly	Monthly	1 Time only	Never	Date of Last Use
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cocaine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Speed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Marijuana	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heroin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pain Medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sleep Medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
PCP/LSD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glue, Paint, Gasoline, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

14. Have you **ever** had any of the following problems?:

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema/Bronchitis
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding tendency/bruising	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia/Pleurisy
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Yellow Jaund./Hepatitis/Liver Cirrhosis
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease/Goiter	<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder trouble or Gallstones
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Stomach trouble/Ulcers
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Bowel disorders/Colitis
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids (piles)
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Cancer/Tumors
<input type="checkbox"/>	<input type="checkbox"/>	Heart trouble or Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Kidney or Bladder trouble
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	Venereal disease (Syphilis, Gonorrhea)
<input type="checkbox"/>	<input type="checkbox"/>	Stroke or Paralysis	<input type="checkbox"/>	<input type="checkbox"/>	Nervous/Emotional problem
<input type="checkbox"/>	<input type="checkbox"/>	Phlebitis/Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>	Pancreatitis
<input type="checkbox"/>	<input type="checkbox"/>	Asthma/Hay fever			
<input type="checkbox"/>	<input type="checkbox"/>	Head Injuries			

15. List any serious illnesses, injuries, and surgeries you have had (give year): _____

Other health conditions not mentioned: _____

Family History:	Check if applicable	Relationship to you:	
Anxiety			
Bipolar Disorder			
Depression			
Alcohol problems			
Drug problems			
Cancer			
High blood pressure			
Thyroid problems			
Heart problems			
Diabetes			
Hallucinations, paranoia			
Suicide or attempts			
Other:			