Confidential Southeastern Health Psychology Questionnaire	
1. Legal Name	_____ (First) (Middle) (Last)
2. Current Marital Status	❑Single ❑Married for ___ years ❑Divorced for ___ years ❑Widowed for ___ years
3. Do you have children?	❑No ❑Yes--If Yes, how many children do you have?
4. Do you have any history of being neglected and/or emotionally, sexually, or physically abuse?	❑No ❑Yes--If Yes, Please describe when, where, and by whom?
5. What is your highest level of education?	❑ ___ Grade ❑G.E.D. ❑High School Diploma ❑Associates Degree ❑Bachelors Degree ❑Masters Degree ❑M.D./D.O ❑J.D. ❑Ph.D. ❑Other:
6. Were you ever held back or failed any grades?	❑No ❑Yes--If Yes, Please list which grades you failed or repeated:
7. Were you ever placed in any remedial or special education classes?	❑No ❑Yes--If Yes, Please list when you were placed in those classes:
8. Have you ever served in the military?	❑No ❑Yes--If Yes, Please list branch and years of service:
9. Are you currently employed?	❑No ❑Yes--If Yes, Please list your job title and the name of employer:
10. Were you ever involved in a work injury and/or motor vehicle accident?	❑No ❑Yes --If Yes, Please provide specifics:
11. Are you current received Workman's Compensation benefits or Social Security Disability (SSDI)?	❑No ❑Yes--If Yes, What benefits are you receiving and when did they begin?
12. Have you ever been convicted of a felony or have any pending legal problems?	❑No ❑Yes --If Yes, Please provide specifics:
13. Have you ever received any previous <u>outpatient</u> mental health care (e.g., psychiatric evaluations, psychotherapy, substance/ alcohol abuse counseling)?	❑No ❑Yes -- If Yes, Please describe the mental health care received and dates:
14. Are you currently drinking caffeinated beverages such as coffee, tea, or colas?	❑No ❑Yes --If Yes, how many drinks do consume in a day?
15. Are you currently smoking cigarettes / cigars / pipes?	❑No ❑Yes --If Yes, how many cigarettes / cigars / pipes do you smoke in a day?
16. Are you currently using chewing tobacco?	❑No ❑Yes --If Yes, how much do you chew in a day?
17. Are you currently drinking alcoholic beverages?	❑No ❑Yes-- If Yes, how many drinks in a day?
18. Do you have a history of using street drugs such as marijuana, cocaine, crack, heroin, ecstasy, crank, LSD, speed, inhalants, etc?	❑No ❑Yes-- If Yes, which drugs have you used and for how long?
19. Have you experienced any recent changes in your appetite?	❑No ❑Yes -- If Yes, which have you experienced: ❑No appetite ❑Decreased appetite ❑Increased appetite ❑Increased cravings for certain foods ❑Nausea/Vomiting when eating or thinking of food ❑Other:
20. Have you experienced any recent changes in your weight?	❑No ❑Yes -- ❑Weight gain of _____ lbs. in _____ months ❑Weight loss of _____ lbs. in _____ months
21. Have you experienced any recent changes in your sleep habits?	❑No ❑Yes -- If Yes, which have you experienced: ❑Difficulty getting to sleep ❑Difficulty staying asleep ❑Waking up earlier than normal ❑Night Sweats ❑Restless sleeping ❑Daytime sleepiness ❑Daytime napping ❑Nightmares ❑Other:

The questions below ask how often you (the individual receiving care) have been bothered by a list of symptoms during the past 7 days. Please respond to each item by marking (✓ or x) one box per row.

	PROMIS Emotional Distress—Depression—Short Form	Never (1)	Rarely (2)	Sometimes (3)	Often (4)	Always (5)
1.	I felt worthless.	❑	❑	❑	❑	❑
2.	I felt that I had nothing to look forward to.	❑	❑	❑	❑	❑
3.	I felt helpless.	❑	❑	❑	❑	❑
4.	I felt sad.	❑	❑	❑	❑	❑
5.	I felt like a failure.	❑	❑	❑	❑	❑
6.	I felt depressed.	❑	❑	❑	❑	❑
7.	I felt unhappy.	❑	❑	❑	❑	❑
8.	I felt hopeless.	❑	❑	❑	❑	❑

	PROMIS Emotional Distress—Anxiety—Short Form	Never (1)	Rarely (2)	Sometimes (3)	Often (4)	Always (5)
1.	I felt fearful.	❑	❑	❑	❑	❑
2.	I felt anxious.	❑	❑	❑	❑	❑
3.	I felt worried.	❑	❑	❑	❑	❑
4.	I found it hard to focus on anything other than my anxiety	❑	❑	❑	❑	❑
5.	I felt nervous.	❑	❑	❑	❑	❑
6.	I felt uneasy.	❑	❑	❑	❑	❑
7.	I felt tense.	❑	❑	❑	❑	❑

	PROMIS Emotional Distress—Anger—Short Form	Never (1)	Rarely (2)	Sometimes (3)	Often (4)	Always (5)
1.	I was irritated more than people knew.	❑	❑	❑	❑	❑
2.	I felt angry.	❑	❑	❑	❑	❑
3.	I felt like I was ready to explode.	❑	❑	❑	❑	❑
4.	I was grouchy.	❑	❑	❑	❑	❑
5.	I felt annoyed.	❑	❑	❑	❑	❑

	Severity Measure for Panic Disorder	Never (0)	Occasionally (1)	Half of the Time (2)	Most of the Time (3)	All of the Time (4)
1.	Felt moments of sudden terror, fear or fright, sometimes out of the blue (i.e., a panic attack)	❑	❑	❑	❑	❑
2.	Felt anxious, worried, or nervous about having more panic attacks	❑	❑	❑	❑	❑
3.	Had thoughts of losing control, dying, going crazy, or other bad things happening because of panic attacks	❑	❑	❑	❑	❑
4.	Felt a racing heart, sweaty, trouble breathing, faint, or shaky	❑	❑	❑	❑	❑
5.	Felt tense muscles, felt on edge or restless, or had trouble relaxing or trouble sleeping	❑	❑	❑	❑	❑
6.	Avoided, or did not approach or enter, situations in which panic attacks might occur	❑	❑	❑	❑	❑
7.	Left situations early, or participated only minimally, because of panic attacks	❑	❑	❑	❑	❑
8.	Spent a lot of time preparing for, or procrastinating about (putting off), situations in which panic attacks might occur	❑	❑	❑	❑	❑
9.	Distracted myself to avoid thinking about panic attacks	❑	❑	❑	❑	❑
10.	Needed help to cope with panic attacks (e.g., alcohol or medication, superstitious objects, other people)	❑	❑	❑	❑	❑

	National Stressful Events Survey PTSD Short Scale (NSESSS)	Not at all (0)	A little bit (1)	Moderately (2)	Quite a bit (3)	Extremely (4)
1.	Having "flashbacks," that is, you suddenly acted or felt as if a stressful experience from the past was happening all over again (for example, you reexperienced parts of a stressful experience by seeing, hearing, smelling, or physically feeling parts of the experience)?	❑	❑	❑	❑	❑
2.	Feeling very emotionally upset when something reminded you of a stressful experience?	❑	❑	❑	❑	❑
3.	Trying to avoid thoughts, feelings, or physical sensations that reminded you of a stressful experience?	❑	❑	❑	❑	❑
4.	Thinking that a stressful event happened because you or someone else (who didn't directly harm you) did something wrong or didn't do everything possible to prevent it, or because of something about you?	❑	❑	❑	❑	❑
5.	Having a very negative emotional state (for example, you were experiencing lots of fear, anger, guilt, shame, or horror) after a stressful experience?	❑	❑	❑	❑	❑
6.	Losing interest in activities you used to enjoy before having a stressful experience?	❑	❑	❑	❑	❑
7.	Being "super alert," on guard, or constantly on the lookout for danger?	❑	❑	❑	❑	❑
8.	Feeling jumpy or easily startled when you hear an unexpected noise?	❑	❑	❑	❑	❑
9.	Being extremely irritable or angry to the point where you yelled at other people, got into fights, or destroyed things?	❑	❑	❑	❑	❑

	Brief Dissociative Experiences Scale (DES-B) - Modified	Not at All (0)	Once or Twice (1)	Almost Every Day (2)	About Once a Day (3)	More than once a Day (4)
1.	I find myself staring into space and thinking of nothing.	❑	❑	❑	❑	❑
2.	People, objects, or the world around me seem strange or unreal.	❑	❑	❑	❑	❑
3.	I find that I did things that I do not remember doing.	❑	❑	❑	❑	❑
4.	When I am alone, I talk out loud to myself.	❑	❑	❑	❑	❑
5.	I feel as though I were looking at the world through a fog so that people and things seem far away or unclear.	❑	❑	❑	❑	❑
6.	I am able to ignore pain.	❑	❑	❑	❑	❑
7.	I act so differently from one situation to another that it is almost as if I were two different people.	❑	❑	❑	❑	❑
8.	I can do things very easily that would usually be hard for me.	❑	❑	❑	❑	❑

	NIDA-Modified ASSSIST	During the past **TWO (2) WEEKS** about how often did you use any of the following medicines ON YOUR OWN, that is, <u>without</u> a doctor's prescription, in greater amounts or longer than prescribed? Not at all (0)	1-2 days (1)	Several Days (2)	More than half the days (3)	Nearly every day (4)
a.	Pain killers (like Vicodin)	❑	❑	❑	❑	❑
b.	Stimulants (like Ritalin, Adderall)	❑	❑	❑	❑	❑
c.	Sedatives or tranquilizers (like sleeping pills or Valium)	❑	❑	❑	❑	❑
d.	Marijuana	❑	❑	❑	❑	❑
e.	Cocaine or crack	❑	❑	❑	❑	❑
f.	Club drugs (like ecstasy)	❑	❑	❑	❑	❑
g.	Hallucinogens (like LSD)	❑	❑	❑	❑	❑
h.	Heroin	❑	❑	❑	❑	❑
i.	Inhalants or solvents (like glue)	❑	❑	❑	❑	❑
j.	Methamphetamine (like speed)	❑	❑	❑	❑	❑

Florida Obsessive-Compulsive Inventory (FOCI) Severity Scale – B	During the past 7 days have you been **bothered by "unwanted repeated thoughts, images, or urges" and/or "being driven to perform certain behaviors or mental acts over and over?"** ❑No ❑Yes If Yes, please complete the following questions:				
1. On average, how much time is occupied by these thoughts or behaviors each day?	❑0—None	❑1—Mild (Less than an hour a day)	❑2—Moderate (1 to 3 hours a day)	❑3—Severe (3 to 8 hours a day)	❑4—Extreme (more than 8 hours a day)
2. How much distress do these thoughts or behaviors cause you?	❑0—None	❑1—Mild (slightly disturbing)	❑2—Moderate (disturbing but still manageable)	❑3—Severe (very disturbing)	❑4—Extreme (overwhelming distress)
3. How hard is it for you to control these thoughts or behaviors?	❑0—Complete control	❑1—Much control (usually able to control thoughts or behaviors)	❑2—Moderate control (sometimes able to control thoughts or behaviors)	❑3—Little control (infrequently able to control thoughts or behaviors)	❑4—No control (unable to control thoughts or behaviors)
4. How much do these thoughts or behaviors cause you to avoid doing anything, going anyplace, or being with anyone?	❑0—No avoidance	❑1—Mild (occasional avoidance)	❑2—Moderate (regularly avoid doing these things)	❑3—Severe (frequent and extensive avoidance)	❑4 - Extreme (nearly complete avoidance; house- bound)
5. How much do these thoughts or behaviors interfere with school, work, or your social or family life?	❑0—None	❑1—Mild (slight interference)	❑2— Moderate; (definite interference with functioning, but still manageable)	❑3—Severe (substantial interference)	❑4—Extreme (near-total interference; incapacitated)

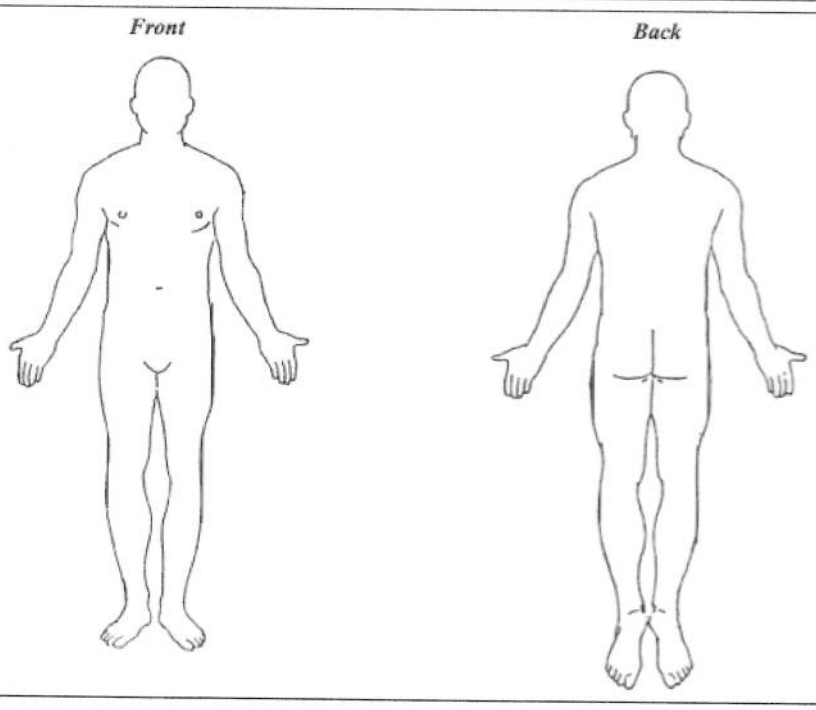
Altman Self-Rating Mania Scale (ASRM)	1. Please read each group of statements/question carefully. 2. Choose the one statement in each group that best describes the way you (the individual receiving care) have been feeling for the **past week**. 3. Check the box (✓ or x) next to the number/statement selected. 4. Please note: The word "occasionally" when used here means once or twice; "often" means several times or more and "frequently" means most of the time.
Question 1	❑1 I do not feel happier or more cheerful than usual. ❑2 I occasionally feel happier or more cheerful than usual. ❑3 I often feel happier or more cheerful than usual. ❑4 I feel happier or more cheerful than usual most of the time. ❑5 I feel happier or more cheerful than usual all of the time.
Question 2	❑1 I do not feel more self-confident than usual. ❑2 I occasionally feel more self-confident than usual. ❑3 I often feel more self-confident than usual. ❑4 I frequently feel more self-confident than usual. ❑5 I feel extremely self-confident all of the time.
Question 3	❑1 I do not need less sleep than usual. ❑2 I occasionally need less sleep than usual. ❑3 I often need less sleep than usual. ❑4 I frequently need less sleep than usual. ❑5 I can go all day and all night without any sleep and still not feel tired.
Question 4	❑1 I do not talk more than usual. ❑2 I occasionally talk more than usual. ❑3 I often talk more than usual. ❑4 I frequently talk more than usual. ❑5 I talk constantly and cannot be interrupted.
Question 5	❑1 I have not been more active (either socially, sexually, at work, home, or school) than usual. ❑2 I have occasionally been more active than usual. ❑3 I have often been more active than usual. ❑4 I have frequently been more active than usual. ❑5 I am constantly more active or on the go all the time.

The questions below ask how often you (the individual receiving care) have been bothered by a list of symptoms during the past 7 days. Please respond to each item by marking (✓ or x) one box per row.

	Patient Health Questionnaire Physical Symptoms (PHQ-15)	Not bothered at all (0)	Bothered a little (1)	Bothered a lot (2)
1.	Stomach pain	❑	❑	❑
2.	Back pain	❑	❑	❑
3.	Pain in your arms, legs, or joints (knees, hips, etc.)	❑	❑	❑
4.	Menstrual cramps or other problems with your periods WOMEN ONLY	❑	❑	❑
5.	Headaches	❑	❑	❑
6.	Chest pain	❑	❑	❑
7.	Dizziness	❑	❑	❑
8.	Fainting spells	❑	❑	❑
9.	Feeling your heart pound or race	❑	❑	❑
10.	Shortness of breath	❑	❑	❑
11.	Pain or problems during sexual intercourse	❑	❑	❑
12.	Constipation, loose bowels, or diarrhea	❑	❑	❑
13.	Nausea, gas, or indigestion	❑	❑	❑
14.	Feeling tired or having low energy	❑	❑	❑
15.	Trouble sleeping	❑	❑	❑

1. Please mark the location on the diagram where and what type of pain you are having:

Achy Pain = ^^^^
Burning = XXXX
Numbness = 0000
Pins & Needles = ++++
Radiating Pain = ////



2. How and when did your pain start?

3.Please rate your pain on a scale of 0-10 with 0 = no pain and 10 = the worst pain imaginable rate:

_____/10 = Current Pain Levels _____/10 = Lowest Pain Levels
_____/10 = Weekly Average Pain Levels _____/10 = Highest Pain Levels

4. What makes your pain worse?

5. What makes your pain better?

6. Please list all of your Physicians, Medical Conditions, and Medications / Dosages.

Physicians	*Medical Issues*	*Medications/Dosages*

7. Are you taking any over-the-counter (OTC) medications or nutritional supplements? ❑No ❑Yes -- If Yes, Please list those OTC medications and/or supplements:

8. Are you allergic to any food or medications? ❑No ❑Yes -- If Yes, Please list all allergies: