

Name: _____ DOB: _____ Age: _____ Date: _____

Are you ALLERGIC to any medicines? No Yes List: _____

How did you hear about us? If someone referred you, who? _____

Internet Insurance company Friend Therapist Physician Unsure/Other _____

If your therapist did not refer you, but you have a therapist, what is their name? _____

BACKGROUND INFORMATION

Tell us about your family & living situation

Names of those living in the same household and names of Children & Step Children *not* living with you:

No one lives with me. I live alone.

<u>Living with you?</u>	<u>Name</u>	<u>Age</u>	<u>Relationship to you</u>
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Yes No _____

Yes No _____

Yes No _____

Yes No _____

Yes No _____

Yes No _____

Are you married? No Yes

Have you ever been divorced? No Yes

Have you ever been remarried? No Yes

Educational, Work, Legal & Religious History

Occupation: _____

Education: Current or highest grade level? _____

Legal: Have you had any legal problems or ongoing problems with custody issues? No Yes

Describe: _____

Religious Beliefs

Are you a Christian? No Yes Unsure

Other Religious beliefs? _____

How important to you is faith in God:

Important Somewhat Important Not Important

Do you now or have you in the past met with others in religious or spiritual community? No Yes

How important is or was this to you?

Important Somewhat Important Not Important

THE PROBLEM WHICH BRINGS YOU HERE:

Why are you here and What are your problems/concerns?

(Briefly explain the problem that brings you here now and what stressful circumstances have contributed to it.)

Suicidal Thoughts, Attempts, or Self-harm

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RAPID MOOD SCREENER

1. Have there been at least 6 different periods of time (at least 2 weeks) when you felt deeply depressed?	<input type="checkbox"/> No <input type="checkbox"/> Yes
2. Did you have problems with depression before the age of 18?	<input type="checkbox"/> No <input type="checkbox"/> Yes
3. Have you ever had to stop or change your antidepressant because it made you highly irritable or hyper?	<input type="checkbox"/> No <input type="checkbox"/> Yes
4. Have you ever had a period of at least 1 week during which you were more talkative than normal with thoughts racing in your head?	<input type="checkbox"/> No <input type="checkbox"/> Yes
5. Have you ever had a period of at least 1 week during which you felt any of the following: unusually happy; unusually outgoing; or unusually energetic?	<input type="checkbox"/> No <input type="checkbox"/> Yes
6. Have you ever had a period of at least 1 week during which you needed much less sleep than usual?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Family History: Do you have any blood relatives with bipolar disorder (or you suspect they might)?	<input type="checkbox"/> No <input type="checkbox"/> Yes

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SLEEP ISSUES

Do you generally feel rested when you wake up in the morning? Yes No

What time do you typically go to bed? _____ What time do you typically fall asleep? _____

What time do you typically wake up? _____

Including naps during the day, how many hours, on average, do you sleep per 24-hour day? _____

If you awaken frequently through the night, how many times do you awaken, and how long does it take you to go back to sleep?

If so, you awaken approximately times? _____ Time it takes to get back to sleep: _____

Have you been prescribed CPAP? Yes If Yes, do you use it regularly? Yes

Do you work shifts or a nontraditional schedule (could include being a caregiver for infant or elderly)? Yes

STOP-BANG Sleep Apnea Questionnaire

STOP

	Yes	No
Do you SNORE loudly (louder than talking or loud enough to be heard through closed doors)?	Yes	No
Do you often feel TIRED , fatigued, or sleepy during the daytime?	Yes	No
Has anyone OBSERVED you stop breathing during your sleep?	Yes	No
Do you have or are you being treated for high blood PRESSURE ?	Yes	No

BANG

	Yes	No
Is your BMI more than 35 kg/m ² ?	Yes	No
Age – Are you over 50 years old?	Yes	No
NECK – Is your neck circumference > 16 inches?	Yes	No
GENDER – Is your biological gender Male?	Yes	No

TOTAL SCORE

High risk of sleep apnea: Yes 5-8

Intermediate risk of OSA: Yes = 3-4

Low risk of OSA: Yes = 0-2

EXERCISE

In a typical week, how many times do you exercise at least 20-30 min (any type, or brisk walking or yoga)?

Less than once per week 1 time 2 times 3 times 4 times 5 times 6 times 7 times

MARITAL ISSUES/ SIGNIFICANT OTHERS

Are you married? Yes No If NO, are you in a steady relationship? Yes No

How would you rate your relationship? Happy Fairly happy Just OK Fairly unhappy Very unhappy

OTHER CONFLICTUAL RELATIONSHIPS

Yes No Are you having significant conflict or stress with anyone other than your spouse? If so, who? _____

SOCIAL SUPPORTS

Yes No Do you experience a lot of loneliness?

Yes No Do you have a close confidant other than spouse? How often do you talk? _____

JOB

How would you rate your work satisfaction? Very happy Fairly happy Just OK Fairly unhappy Very unhappy

PROBLEMS WITH EMOTIONAL INSTABILITY

Having problems with emotional instability means having unstable relationships, low self-esteem, and problems with impulsive behavior, beginning by late adolescence or early adulthood.

Problems with emotional instability – do you tend to:

- Make frantic efforts to avoid real or imagined abandonment.
- Have a pattern of difficult relationships caused by alternating between extremes of intense admiration and hatred of others.
- Have an unstable self-image or be unsure of his or her own identity.
- Act impulsively in ways that are self-damaging, such as extravagant spending, sex with many partners, substance abuse, binge eating, or reckless driving.
- Have recurring suicidal thoughts, make repeated suicide attempts, or cause self-injury through mutilation, such as cutting or burning oneself.
- Have frequent emotional overreactions or intense mood swings, including feeling depressed, irritable, or anxious. These mood swings may only last a few hours at a time. In rare cases, they may last a day or two.
- Have long-term feelings of emptiness.
- Have inappropriate, fierce anger or problems controlling anger – or often display temper tantrums or get into fights.
- Have temporary episodes of feeling suspicious of others without reason (paranoia) or losing a sense of reality.

MEDICATIONS – CURRENT and PAST MEDICATIONS

List ALL CURRENT MEDICATIONS, VITAMINS, HERBAL, & SUPPLEMENTS that you are now taking:

Medication, Vitamin, or Herbal	Medication, Vitamin, or Herbal	Medication, Vitamin, or Herbal

List ALL PAST MEDICATIONS that you have taken:

√ if Taking Now or Past	Medication Have you <i>ever</i> taken any of these:	dose	When & Why Stopped	When	√ if Taking Now or Past	Medication Have you <i>ever</i> taken any of these:	dose	When & Why Stopped	When
<input type="checkbox"/> Now <input type="checkbox"/> Past	Ritalin/Methylin				<input type="checkbox"/> Now <input type="checkbox"/> Past	Abilify			
<input type="checkbox"/> Now <input type="checkbox"/> Past	Metadate				<input type="checkbox"/> Now <input type="checkbox"/> Past	Aristada or Maintena			
<input type="checkbox"/> Now <input type="checkbox"/> Past	Mydayis				<input type="checkbox"/> Now <input type="checkbox"/> Past	Rexulti			
<input type="checkbox"/> Now <input type="checkbox"/> Past	Aptensio				<input type="checkbox"/> Now <input type="checkbox"/> Past	Geodon			
<input type="checkbox"/> Now <input type="checkbox"/> Past	Concerta				<input type="checkbox"/> Now <input type="checkbox"/> Past	Risperdal/Invega			
<input type="checkbox"/> Now <input type="checkbox"/> Past	Focalin (or XR)				<input type="checkbox"/> Now <input type="checkbox"/> Past	Zyprexa			
<input type="checkbox"/> Now <input type="checkbox"/> Past	Daytrana				<input type="checkbox"/> Now <input type="checkbox"/> Past	Seroquel (or XR)			
<input type="checkbox"/> Now <input type="checkbox"/> Past	Adderall (or XR)				<input type="checkbox"/> Now <input type="checkbox"/> Past	Saphris			
<input type="checkbox"/> Now <input type="checkbox"/> Past	Vyvanse				<input type="checkbox"/> Now <input type="checkbox"/> Past	Fanapt			
<input type="checkbox"/> Now <input type="checkbox"/> Past	Other stimulant				<input type="checkbox"/> Now <input type="checkbox"/> Past	Latuda			
<input type="checkbox"/> Now <input type="checkbox"/> Past	Strattera				<input type="checkbox"/> Now <input type="checkbox"/> Past	Vraylar			
<input type="checkbox"/> Now <input type="checkbox"/> Past	Qelbree				<input type="checkbox"/> Now <input type="checkbox"/> Past	Caplyta			
<input type="checkbox"/> Now <input type="checkbox"/> Past	Clonidine				<input type="checkbox"/> Now <input type="checkbox"/> Past	Clozapine			
<input type="checkbox"/> Now <input type="checkbox"/> Past	Guanfacine				<input type="checkbox"/> Now <input type="checkbox"/> Past	Lithium			
<input type="checkbox"/> Now <input type="checkbox"/> Past	Prozac				<input type="checkbox"/> Now <input type="checkbox"/> Past	Depakote			
<input type="checkbox"/> Now <input type="checkbox"/> Past	Zoloft				<input type="checkbox"/> Now <input type="checkbox"/> Past	Tegretol (Carbamazepine)			
<input type="checkbox"/> Now <input type="checkbox"/> Past	Paxil				<input type="checkbox"/> Now <input type="checkbox"/> Past	Trileptal			
<input type="checkbox"/> Now <input type="checkbox"/> Past	Luvox				<input type="checkbox"/> Now <input type="checkbox"/> Past	Lamictal (lamotrigine)			
<input type="checkbox"/> Now <input type="checkbox"/> Past	Celexa				<input type="checkbox"/> Now <input type="checkbox"/> Past	Topamax			
<input type="checkbox"/> Now <input type="checkbox"/> Past	Lexapro				<input type="checkbox"/> Now <input type="checkbox"/> Past	Valium (Diazepam)			
<input type="checkbox"/> Now <input type="checkbox"/> Past	Effexor XR				<input type="checkbox"/> Now <input type="checkbox"/> Past	Xanax (Alprazolam)			
<input type="checkbox"/> Now <input type="checkbox"/> Past	Pristiq				<input type="checkbox"/> Now <input type="checkbox"/> Past	Ativan (Lorazepam)			
<input type="checkbox"/> Now <input type="checkbox"/> Past	Cymbalta				<input type="checkbox"/> Now <input type="checkbox"/> Past	Klonopin (Clonazepam)			
<input type="checkbox"/> Now <input type="checkbox"/> Past	Wellbutrin				<input type="checkbox"/> Now <input type="checkbox"/> Past	Lyrica			
<input type="checkbox"/> Now <input type="checkbox"/> Past	Remeron				<input type="checkbox"/> Now <input type="checkbox"/> Past	Neurontin			
<input type="checkbox"/> Now <input type="checkbox"/> Past	Bupirone				<input type="checkbox"/> Now <input type="checkbox"/> Past	Hydroxyzine			
<input type="checkbox"/> Now <input type="checkbox"/> Past	Trintellix				<input type="checkbox"/> Now <input type="checkbox"/> Past	Ambien (or CR)			
<input type="checkbox"/> Now <input type="checkbox"/> Past	Viibryd				<input type="checkbox"/> Now <input type="checkbox"/> Past	Lunesta			
<input type="checkbox"/> Now <input type="checkbox"/> Past	Fetzima				<input type="checkbox"/> Now <input type="checkbox"/> Past	Temazepam			
<input type="checkbox"/> Now <input type="checkbox"/> Past	Nefazodone				<input type="checkbox"/> Now <input type="checkbox"/> Past	Sonata			
<input type="checkbox"/> Now <input type="checkbox"/> Past	Amitriptyline				<input type="checkbox"/> Now <input type="checkbox"/> Past	Trazodone			
<input type="checkbox"/> Now <input type="checkbox"/> Past	Imipramine				<input type="checkbox"/> Now <input type="checkbox"/> Past	Rozerem			
<input type="checkbox"/> Now <input type="checkbox"/> Past	EMSAM				<input type="checkbox"/> Now <input type="checkbox"/> Past	Melatonin			
<input type="checkbox"/> Now <input type="checkbox"/> Past	Nardil				<input type="checkbox"/> Now <input type="checkbox"/> Past	Benadryl (antihistamine)			
<input type="checkbox"/> Now <input type="checkbox"/> Past	Pamate				<input type="checkbox"/> Now <input type="checkbox"/> Past	Other OTC sleep aid			
<input type="checkbox"/> Now <input type="checkbox"/> Past	Ketamine				<input type="checkbox"/> Now <input type="checkbox"/> Past	Buprenorphine			
<input type="checkbox"/> Now <input type="checkbox"/> Past	Provigil/Nuvigil				<input type="checkbox"/> Now <input type="checkbox"/> Past	Antabuse (disulfiram)			
<input type="checkbox"/> Now <input type="checkbox"/> Past	Aricept (donepezil)				<input type="checkbox"/> Now <input type="checkbox"/> Past	Campral (acamprosate)			
<input type="checkbox"/> Now <input type="checkbox"/> Past	Namenda (memantine)				<input type="checkbox"/> Now <input type="checkbox"/> Past	Naltrexone (oral or injectable)			