MASSACHUSETTS GENERAL HOSPITAL

Patient Name: _____
MGH MRN#: _____
Today's Date: _____

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionaire are strictly confidential
and will become part of your medical record

PATIENT:

Name:
Date of birth:
Address:

Home Phone:
Work Phone:

Residence is:

☐ Private Residence - ***(Please circle one)***
Alone With Significant Other
With Family With Friend
With Spouse
☐ Dormitory
☐ Apartment attached to Caregiver/Family residence
☐ Assisted Living
☐ Institution (Date admitted?_____)
☐ Other

Please complete the following questionnaire which seeks information about your past medical history, medication use and related issues. This confidential information will assist your clinician in providing the best care possible. Further information will be obtained during your visit, and we will try to address any questions that you have.

REASON(S) FOR VISIT:

☐ Tics/Tourette Syndrome
☐ Obsessions and/or compulsions
☐ Difficulty with attention and concentration
☐ Hyperactivity/restlessness
☐ Anger outbursts
☐ Difficulty with school/learning
☐ Problem with reading or writing
☐ Feeling depressed
☐ Feeling anxious
☐ Other:_____

Please give a brief description:

RELEASE INFORMATION: Please list any other healthcare providers. For example, your primary care physician, neurologist, psychiatrist, therapist or the healthcare provider who referred you to our clinic.

Doctor:

Address:

Phone Number:

Doctor:

Address:

Phone Number:

Are you interested in learning more about participating in clinical research studies? ☐ Yes ☐ No

MASSACHUSETTS GENERAL HOSPITAL

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CURRENT MEDICATIONS: Please list current medications and dose. Bring or attach a list if necessary.

_____ _____
_____ _____
_____ _____

CURRENT OTC MEDICATIONS: Please list current over-the-counter medications (OTC), including vitamins, herbal remedies or supplements, and medications for pain, sleep, etc…

_____ _____
_____ _____
_____ _____

PREVIOUS MEDICATIONS: Please indicate if you felt the medication was helpful.

_____ _____
_____ _____
_____ _____

FAMILY HISTORY: Does anyone in your family have (or had) any of the following conditions? If so, whom?:

- ☐ Tourette Syndrome
- ☐ Motor or vocal tics
- ☐ Obsessive-compulsive disorder
- ☐ Attention-deficit/hyperactivity disorder
- ☐ Autism Spectrum Disorder
- ☐ Seizures/Epilepsy
- ☐ Adult-onset diabetes
- ☐ High cholesterol
- ☐ Other Neurological/Psychiatric disease; if yes what?

IMMUNIZATIONS: Are all of your/ your child's immunizations up-to-date ☐ Yes ☐ No

Do you experience chronic pain? ☐ Yes ☐ No

Please explain:

Do you have any drug allergies?

- ☐ Yes
- ☐ No

Specify: _____

_____

What happens? _____

_____

Are you concerned that someone at home or in your neighborhood will hurt you?

- ☐ Yes
- ☐ No

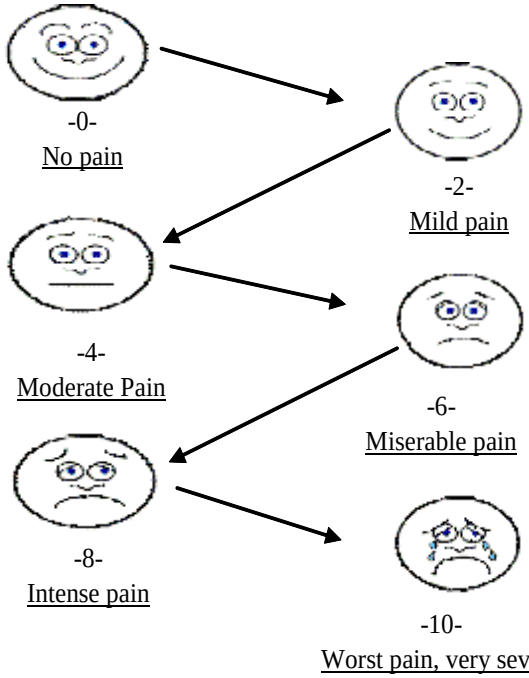
Do you smoke cigarettes? ☐ Yes ☐ No

How much alcohol do you consume in a week? _____

Do you use or have you recently used recreational drugs?

If so, please list: _____

Which best describes any pain that you are having?



MASSACHUSETTS GENERAL HOSPITAL

Patient Name: _____
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Today's Date: _____

PATIENT MEDICAL HISTORY/REVIEW OF SYMPTOMS:

Have you/your child ever had any of the following, or are you having difficulties with any of the following items? (Please check even if treated or controlled, but please indicate this in the margin)

General
- ☐ Frequent fevers/chills
- ☐ Body aches
- ☐ Fatigue
- ☐ Unexpected weight changes
- ☐ Other

Skin
- ☐ Mole changes/growth
- ☐ Skin rashes
- ☐ Itchy skin
- ☐ Skin dryness
- ☐ Other

Lymphatic
- ☐ Bruising
- ☐ Bleeding
- ☐ Swollen glands
- ☐ Immune problems
- ☐ Anemia/B12 deficiency
- ☐ Other

Lungs/Heart
- ☐ Shortness of breath
- ☐ Persistent cough
- ☐ Wheezing
- ☐ Chest pain
- ☐ Heart palpitations
- ☐ Leg cramps
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Heart attack
- ☐ Other

Psychological
- ☐ Frequent crying
- ☐ Being afraid or having fearful thoughts
- ☐ Suicidal thoughts
- ☐ Insomnia
- ☐ Problems oversleeping
- ☐ Treatment for depression
- ☐ Therapy for emotional problems
- ☐ Tension, Stress or Anxiety
- ☐ Anger outbursts
- ☐ Major mental illness
- ☐ Addiction(s)
- ☐ Trouble with the law
- ☐ Difficulty interacting with peers
- ☐ Other

Muscles
- ☐ Painful joints
- ☐ Stiffness
- ☐ Upper back pain
- ☐ Lower back pain
- ☐ Other

Gastrointestinal
- ☐ Loss of appetite
- ☐ Nausea or vomiting
- ☐ Hepatitis
- ☐ Heartburn
- ☐ Ulcers
- ☐ Constipation
- ☐ Diarrhea
- ☐ Other

Neurological
- ☐ Headaches
- ☐ Migraines
- ☐ Decreased, blurred or double vision
- ☐ Dizziness/vertigo
- ☐ Ringing in the ears
- ☐ Fainting
- ☐ Unsteadiness while walking
- ☐ Difficulty chewing/swallowing
- ☐ Hoarseness/change in voice
- ☐ Numbness
- ☐ Weakness
- ☐ Drowsiness
- ☐ Head injury or concussion
- ☐ Tremor/ shaking
- ☐ Memory problems
- ☐ Seizures
- ☐ Stroke
- ☐ Falls
- ☐ Other

Endocrine and Genitourinary
- ☐ Diabetes
- ☐ Thyroid trouble
- ☐ Excessive sweating or night sweats
- ☐ Kidney disease
- ☐ Hot flashes or heat intolerance
- ☐ Sexual difficulties
- ☐ Unusual discharge
- ☐ Pain or burning w/ urination
- ☐ Change in urinary frequency
- ☐ Sexually transmitted disease
- ☐ Removal of uterus
- ☐ Removal of ovaries
- ☐ Other

Have you ever had a picture or image taken of your brain? ☐ Yes ☐ No
If available, please bring a copy of this report and copies of actual films, if available.

Previous surgeries or procedures (include dates if known):

_____

_____

PATIENT DETAILS AND DEMOGRAPHICS:

Handedness:
☐ Right
☐ Left
☐ Ambidextrous

Primary Language:
☐ English
☐ Spanish
☐ Other

Did you learn English after a first language?
☐ Yes
☐ No

Birth History:

Duration of pregnancy (in weeks): _____

Birth Weight: _____

Any complications? ☐ Yes ☐ No

Pregnancy (diabetes, pre-eclampsia, drug/alcohol use, injury, emotional problems, stress, other): _____

Labor: _____

Delivery (vaginal, C-section, forceps, etc.): _____

Newborn Period (breathing problems, incubator, infection, jaundice requiring treatment): _____

Did you/your child go home from the hospital with your/his/her parents? ☐ Yes ☐ No

Developmental Milestones:

At what age did you/your child first:

sit unassisted?

crawl?

walk?

speak 1st words?

use 2-3 word sentences?

toilet train?

Social History:

For patients under age 21 (or older if relevant):

Are both parents living in the home? ☐ Yes ☐ No ☐ Separated ☐ Divorced ☐ Deceased

Is patient adopted? In foster care?

Who has custody of the patient?

How often does patient see non-custodial parent?

Please list any people residing at home with the patient (include age and relation):

PATIENT DETAILS AND DEMOGRAPHICS continued:

School History:

For patients under age 21 (or older if relevant):

Current School: Grade:

Type of Program: ☐ Public ☐ Private
☐ Regular Ed ☐ Special Ed (specify type)

If applicable, please check boxes next to special services received (current or past): ☐ Not applicable

☐ Resource Room ☐ Physical Therapy ☐ Counseling
☐ Speech/Language ☐ Occupational Therapy ☐ 1:1 Aide
☐ Other

Have any learning disabilities been identified? If so, what are they and in what grade were they identified?

If you/your child is receiving special services, please include copies of any evaluations and your current IEP.

For patients over age 21 (or younger if relevant):

Are you currently: ☐ single ☐ married ☐ separated ☐ divorced

Education:

What was the highest level of education completed?

☐ Elementary School -5yrs
☐ Middle School - 8yrs
☐ High School (Some) - 10yrs
☐ High School Graduate -12yrs
☐ College (Associate's) -14yrs
☐ College (Bachelor's) -16yrs
☐ Graduate or Professional School -18+ yrs

Type of Work: _____
(please give previous if retired)

Current or previous average hours/wk: _____

For all patients:

What non-school (or non-work) activities do you enjoy? _____

_____

Do you belong to any groups, teams or organizations? _____

_____

Please list any talents, special abilities and strengths: _____

_____

Patient Name: _____
MGH MRN#: _____
Today's Date: _____

Race and Ethnicity: (select one or more)

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic or Latino
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Caucasian
- ☐ Other: _____

Please use this space to explain any checked items from above, any answers marked 'Other', or any concerns you'd like us to know about.

Date:_____Time:_____Patient/Guardian Signature:_____

Date:_____Time:_____Physician Signature:_____Clinical ID#_____

Name:_____ Date:_____

Tic Questionnaire

When completing this questionnaire, please refer to these motor and vocal tic definitions:
Simple motor tics: Any sudden purposeless movements that happen repeatedly such as eye blinking or shoulder shrugging.
Complex motor tics: Any repeated movements that are always done in the same way and involve more than one muscle group like eyes and mouth, or shoulder and arm. These tics may seem like they are being done on purpose or intentionally at times, but usually they are not.
Simple vocal tics: Any sudden sounds that appear meaningless and that happen repeatedly, such as excessive sniffling or throat clearing.
Complex vocal tics: Purposeful in appearance, these tics often mimic brief meaningful utterances such as repeating parts of words, whole words, or phrases when it doesn't make sense to do so or is inappropriate.

Please check the appropriate box.

Never	Ever	Current	I have experienced, or others have noticed, involuntary and apparently purposeless bouts of:	OFFICE USE: (complexity)
			Simple eye movements such as: eye blinking, squinting, eyebrow raising , or opening eyes wide (briefly)	0
			Complex eye movements such as: looking surprised or quizzical, eye rolling.	2
			Nose movements such as: nose twitching, broadening or flaring of the nostrils.	1
			Simple mouth movements such as: opening mouth wide, pouting.	1
			Complex mouth movements such as: smiling, sticking out tongue, grimacing or other gestures involving the mouth.	2
			Head movements such as head shaking, head jerks, touching the chin to shoulder, lifting chin up or throwing the head back (as if to get hair out of the eyes).	1
			Simple shoulder movements such as: quickly jerking a shoulder	0
			Complex shoulder movements such as: slowly shrugging shoulders as if to say "I don't know"	1
			Simple hand or arm movements such as: quickly flexing or extending the hands, fingers or arms.	2
			Complex, coordinated hand and arm movements involving multiple muscle groups such as: hand and arm postures and, pinching or, moving fingers in a sequence.	3
			Simple leg/foot movements such as: kicking, flexing, bending or extending the ankles or feet.	1
			Complex leg/foot movements such as: skipping, hopping, jumping, taking one step forward and two steps back, squatting, deep knee bending.	4
			Repeatedly tensing the abdomen or buttocks	1
			Rude/obscene gestures; rude/obscene hand/finger gestures	5
			Complex compulsive motor tics such as: touching, tapping, or evening-up.	3
			Simple vocal tics such as: coughing, throat clearing, sniffing, snorting, humming, or grunting.	0
			Vocal tics such as: whistling (as a tic) or making animal or bird noises.	2
			Vocal tics such as: uttering syllables	2
			Vocal tics such as: uttering (non-obscene) words	3
			Repeatedly uttering rude or obscene words or phrases (as a tic).	5
			Repeating what someone else has said (sounds, single words, or sentences)	4
			Repeating something that you have said over and over again	4

At what age did your tics begin? _____ **years old** ☐ **Not sure/don't remember**

Are your tics still present? ☐ Yes ☐ No

Do you know when they are coming? ☐ Yes ☐ No

Can you control them (even just briefly)? ☐ Yes ☐ No

Have your tics occurred for a period of more than one year, even if they come and go? ☐ Yes ☐ No

Do/did the tics change over time (some tics disappear, while others appear)? ☐ Yes ☐ No

Have you been diagnosed with Tourette Syndrome by a clinician? Y N

What kind of clinician was it? neurologist psychiatrist psychologist pediatrician other

Name:_____ Date:_____

MOTOR TICS Check one box per line for each question about your current **motor** tics (in the past week)

Number of Current Motor Tics:	0 None ☐	1 **Single** motor tic ☐	2 **2-5** different motor tics ☐	3 **More than 5** different motor tics ☐	4 Multiple different tics plus **at least one pattern** of multiple tics happening together or in a sequence so it is hard to tell them apart ☐	5 Multiple different tics plus **more than 2 patterns** of multiple tics happening together or in a sequence so it is hard to tell them apart ☐
Frequency of Current Motor Tics:	0 No tics ☐	1 **Rarely have motor tics:** tics present during the past week, but not on daily basis ☐	2 **Occasionally have motor tics:** tics present daily but with long tic-free periods during the day ☐	3 **Frequently have motor tics:** tics present daily with tic-free periods as long as 3 hours ☐	4 **Almost Always have motor tics:** tics present every hour of the day ☐	5 **Always have motor tics:** tics present all the time with tic-free periods lasting only 5 to 10 minutes ☐
Intensity of Current Motor Tics:	0 No tics ☐	1 **Minimal Strength:** Motor tics are less strong than regular actions; they are generally not noticed by others ☐	2 **Mild Strength:** Motor tics are the same strength as regular actions ☐	3 **Moderate Strength:** Motor tics are stronger than regular actions and might call attention from others ☐	4 **Marked Strength:** Motor tics are stronger than regular actions and have an exaggerated quality. They frequently call attention from others ☐	5 **Severe Strength:** Motor tics are very strong and exaggerated and may cause physical injury because of their severity ☐
Interference (when motor tics are present):	0 None ☐	1 **Minimal:** tics do not interrupt the flow of activity or actions ☐	2 **Mild:** tics sometimes interrupt the flow of activity or actions ☐	3 **Moderate:** tics often interrupt the flow of activity or actions ☐	4 **Marked:** tics often interrupt the flow of activity or actions and they sometimes completely disrupt actions ☐	5 **Severe:** tics often disrupt actions ☐
FOR OFFICE USE ONLY Complexity of Motor Tics:	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐

Please Turn Page -->

VOCAL TICS Check one box per line for each question about your current **vocal** tics (in the past week)

	0	1	2	3	4	5
Number of Current Vocal Tics:	None ☐	**Single** vocal tic ☐	**2-5** different vocal tics ☐	**More than 5** different vocal tics ☐	Multiple different tics plus **at least one pattern** of multiple tics happening together or in a sequence so it is hard to tell them apart ☐	Multiple different tics plus **more than 2 patterns** of multiple tics happening together or in a sequence so it is hard to tell them apart ☐
Frequency of Current Vocal Tics:	No tics ☐	**Rarely have vocal tics:** present during the past week, but not on daily basis ☐	**Occasionally have vocal tics:** tics present daily but with long tic-free periods during the day ☐	**Frequently have vocal tics:** tics present daily with tic-free periods as long as 3 hours ☐	**Almost Always have vocal tics:** tics present every hour of the day ☐	**Always have vocal tics:** tics present all the time with tic-free periods lasting only 5 to 10 minutes ☐
Intensity of Current Vocal Tics:	No tics ☐	**Minimal Strength:** Vocal tics are less strong than regular actions; they are generally not noticed by others ☐	**Mild Strength:** Vocal tics are the same strength as regular actions ☐	**Moderate Strength:** Vocal tics are stronger than regular actions and might call attention from others ☐	**Marked Strength:** Vocal tics are stronger than regular actions and have an exaggerated quality. They frequently call attention from others ☐	**Severe Strength:** Vocal tics are very strong and exaggerated and may cause physical injury because of their severity ☐
Interference (when vocal tics are present):	None ☐	**Minimal**: tics do not interrupt the flow of speech ☐	**Mild**: tics sometimes interrupt the flow of speech ☐	**Moderate:** tics often interrupt the flow of speech ☐	**Marked:** tics often interrupt the flow of speech, and they sometimes completely disrupt communication ☐	**Severe:** tics often disrupt communication ☐
FOR OFFICE USE ONLY Complexity of Vocal Tics:	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐

Name:_____ Date:_____

FOCI

Have you been bothered by unpleasant thoughts or images that repeatedly enter your mind, such as:

	In the past month?	Ever?
1. Concerns with contamination (dirt, germs, chemicals, radiation) or acquiring a serious illness such as AIDS?	☐Yes ☐ No	☐Yes ☐ No
2. Overconcern with keeping objects (clothing, tools, etc) in perfect order or arranged exactly?	☐Yes ☐ No	☐Yes ☐ No
3. Images of death or other horrible events?	☐Yes ☐ No	☐Yes ☐ No
4. Personally unacceptable religious or sexual thoughts?	☐Yes ☐ No	☐Yes ☐ No
Have you worried a lot about terrible things happening, such as:		
5. Fire, burglary or flooding of the house?	☐Yes ☐ No	☐Yes ☐ No
6. Accidentally hitting a pedestrian with your car or letting it roll down a hill?	☐Yes ☐ No	☐Yes ☐ No
7. Spreading an illness (giving someone AIDS)?	☐Yes ☐ No	☐Yes ☐ No
8. Losing something valuable?	☐Yes ☐ No	☐Yes ☐ No
9. Harm coming to a loved one because you weren't careful enough?	☐Yes ☐ No	☐Yes ☐ No
Have you worried about acting on an unwanted and senseless urge or impulse, such as:		
10. Physically harming a loved one, pushing a stranger in front of a bus, steering your car into oncoming traffic; inappropriate sexual contact; or poisoning dinner guests?	☐Yes ☐ No	☐Yes ☐ No
Have you felt driven to perform certain acts over and over again, such as:		
11. Excessive or ritualized washing, cleaning or grooming?	☐Yes ☐ No	☐Yes ☐ No
12. Checking light switches, water faucets, the stove, door locks or the emergency brake?	☐Yes ☐ No	☐Yes ☐ No
13. Counting, arranging; evening-up behaviors (making sure socks are at same height)?	☐Yes ☐ No	☐Yes ☐ No
14. Collecting useless objects or inspecting the garbage before it is thrown out?	☐Yes ☐ No	☐Yes ☐ No
15. Repeating routine actions (in/out of chair, going through doorway, relighting cigarette) a certain number of times or until it feels just right?	☐Yes ☐ No	☐Yes ☐ No
16. Needing to touch objects or people?	☐Yes ☐ No	☐Yes ☐ No
17. Unnecessary rereading or rewriting; reopening envelopes before they are mailed?	☐Yes ☐ No	☐Yes ☐ No
18. Examining your body for signs of illness?	☐Yes ☐ No	☐Yes ☐ No
19. Avoiding colors ("red" means blood), numbers ("13" is unlucky) or names (those that start with "D" signify death) that are associated with dreaded events or unpleasant thoughts?	☐Yes ☐ No	☐Yes ☐ No
20. Needing to "confess" or repeatedly asking for reassurance that you said or did something correctly?	☐Yes ☐ No	☐Yes ☐ No

If you answered YES to three or more of these questions, please continue below.

Please Turn Page →

The following questions refer to the repeated thoughts, images, urges or behaviors identified above.
Check the box for the most appropriate number from 0 to 4 for how they have been in the last 30 days and also for how they were when they were their worst ever.

On average, how much time is occupied by these thoughts or behaviors each day? **In last 30 days** **Worst ever time**	0 none ☐ ☐	1 mild (less than 1 hour) ☐ ☐	2 moderate (1-3 hours) ☐ ☐	3 severe (3-8 hours) ☐ ☐	4 extreme (more than 8 hours) ☐ ☐
How much distress do they cause you? **In last 30 days** **Worst ever time**	0 none ☐ ☐	1 mild ☐ ☐	2 moderate ☐ ☐	3 severe ☐ ☐	4 extreme ☐ ☐
How hard is it for you to control them? **In last 30 days** **Worst ever time**	0 complete control ☐ ☐	1 much control ☐ ☐	2 moderate control ☐ ☐	3 little control ☐ ☐	4 no control ☐ ☐
How much do they cause you to avoid doing anything, going anyplace, or being with anyone? **In last 30 days** **Worst ever time**	0 no avoidance ☐ ☐	1 occasional avoidance ☐ ☐	2 moderate avoidance ☐ ☐	3 frequent and extensive avoidance ☐ ☐	4 extreme avoidance (housebound) ☐ ☐
How much do they interfere with school, work or your social or family life? **In last 30 days** **Worst ever time**	0 none ☐ ☐	1 slight interference ☐ ☐	2 definitely interferes with functioning ☐ ☐	3 much interference ☐ ☐	4 extreme interference (disabling) ☐ ☐
Office Use: Total score last 30 days (max=20)	_____				
Office Use: Total score worst ever time (max=20)_____	_____				

At what age did the symptoms begin? _____
At what age were they their worst? _____

Name:_____ Date:_____

The SNAP-IV Rating Scale

James M. Swanson, Ph.D.

For each item, check the column which best describes you when you were a child:	Not At All	Just A Little	Quite A Bit	Very Much
1. Often failed to give close attention to details or made careless mistakes in schoolwork or tasks	____	____	____	____
2. Often had difficulty sustaining attention in tasks or play activities	____	____	____	____
3. Often did not seem to listen when spoken to directly	____	____	____	____
4. Often did not follow through on instructions and failed to finish schoolwork, chores, or duties	____	____	____	____
5. Often had difficulty organizing tasks and activities	____	____	____	____
6. Often avoided, disliked, or reluctantly engaged in tasks requiring sustained mental effort	____	____	____	____
7. Often lost things necessary for activities (e.g., toys, school assignments, pencils, or books)	____	____	____	____
8. Often was distracted by extraneous stimuli	____	____	____	____
9. Often was forgetful in daily activities	____	____	____	____
10. Often had difficulty maintaining alertness, orienting to requests, or executing directions	____	____	____	____
11. Often fidgeted with hands or feet or squirmed in seat	____	____	____	____
12. Often left seat in classroom or in other situations in which remaining seated was expected	____	____	____	____
13. Often ran about or climbed excessively in situations in which it was inappropriate	____	____	____	____
14. Often had difficulty playing or engaging in leisure activities quietly	____	____	____	____
15. Often was "on the go" or often acted as if "driven by a motor"	____	____	____	____
16. Often talked excessively	____	____	____	____
17. Often blurted out answers before questions had been completed	____	____	____	____
18. Often had difficulty awaiting turn	____	____	____	____
19. Often interrupted or intruded on others (e.g., butted into conversations/games)	____	____	____	____
20. Often had difficulty sitting still, being quiet, or inhibiting impulses in the classroom or at home	____	____	____	____
21. Often loses temper	____	____	____	____
22. Often argues with adults	____	____	____	____
23. Often actively defies or refuses adult requests or rules	____	____	____	____
24. Often deliberately does things that annoy other people	____	____	____	____
25. Often blames others for his or her mistakes or misbehavior	____	____	____	____
26. Often touchy or easily annoyed by others	____	____	____	____
27 Often is angry and resentful	____	____	____	____
28. Often is spiteful or vindictive	____	____	____	____
29. Often is quarrelsome	____	____	____	____
30. Often is negative, defiant, disobedient, or hostile toward authority figures	____	____	____	____
31. Often makes noises (e.g., humming or odd sounds)	____	____	____	____
32. Often is excitable, impulsive	____	____	____	____
33. Often cries easily	____	____	____	____
34. Often is uncooperative	____	____	____	____
35. Often acts "smart"	____	____	____	____
36. Often is restless or overactive	____	____	____	____
37. Often disturbs other children	____	____	____	____
38. Often changes mood quickly and drastically	____	____	____	____
39. Often easily frustrated if demand are not met immediately	____	____	____	____
40. Often teases other children and interferes with their activities	____	____	____	____
41. Often is aggressive to other children (e.g., picks fights or bullies)	____	____	____	____
42. Often is destructive with property of others (e.g., vandalism)	____	____	____	____
43. Often is deceitful (e.g., steals, lies, forges, copies the work of others, or "cons" others)	____	____	____	____
44. Often and seriously violates rules (e.g., is truant, runs away, or completely ignores class rules)	____	____	____	____
45. Has persistent pattern of violating the basic rights of others or major societal norms	____	____	____	____

Did any of these symptoms begin before age 7? Y N

If you answered "quite a bit" or "very much" to any of items 1-10, at what age did they begin? _____

If you answered "quite a bit" or "very much" to any of items 11-20, at what age did they begin? _____

Did these symptoms cause you difficulties at home? Y N

Did these symptoms cause you difficulties at school? Y N

Did these symptoms cause you difficulties in other public settings (church, synagogue, the grocery store, etc)? Y N

Did these problems interfere with your family life? Y N

Did these problems interfere with your social relations? Y N

Did these problems interfere with your daily life at school? Y N

Do you still have trouble with these symptoms? Y N

Have you ever been diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD)? Y N

If yes, by whom? neurologist psychiatrist psychologist pediatrician other

How old were you when you were diagnosed? _____

Name:_____ Date:_____

SPIN
(Jonathan Davidson 1998)

	Not at all	A little bit	Somewhat	Very much	Extremely
1. Fear of embarrassment causes me to avoid doing things or speaking to people.	0	1	2	3	4
2. I avoid activities in which I am the center of attention.	0	1	2	3	4
3. Being embarrassed or looking stupid are among my worst fears.	0	1	2	3	4
4. I am afraid of people in authority.	0	1	2	3	4
5. I am bothered by blushing in front of people.	0	1	2	3	4
6. Parties and social events scare me.	0	1	2	3	4
7. I avoid talking to people I don't know.	0	1	2	3	4
8. Being criticized scares me a lot.	0	1	2	3	4
9. Sweating in front of people causes me distress.	0	1	2	3	4
10. I avoid going to parties.	0	1	2	3	4
11. Talking to strangers scares me.	0	1	2	3	4
12. I avoid having to give speeches.	0	1	2	3	4
13. I would do anything to avoid being criticized.	0	1	2	3	4
14. Heart palpitations bother me when I am around people.	0	1	2	3	4
15. I am afraid of doing things when people might be watching.	0	1	2	3	4
16. I avoid speaking to anyone in authority.	0	1	2	3	4
17. Trembling or shaking in front of others is distressing to me.	0	1	2	3	4
Add the score for each column	____	____	____	____	____
Total Score (add the column scores, max=60)	____				

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Worrying too much about different things	0	1	2	3
Having trouble relaxing	0	1	2	3
Being so restless that it's hard to sit still	0	1	2	3
Becoming easily annoyed or irritable	0	1	2	3
Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	____	____	____	____
Total Score *(add the column scores, max = 21)*	____			

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐Not difficult at all ☐Somewhat difficult ☐Very difficult ☐Extremely difficult

Name:_____ Date:_____

QUICK INVENTORY OF DEPRESSIVE SYMPTOMATOLOGY (SELF-REPORT) (QIDS-SR 16)

Please circle the one response to each item that best describes you for the past seven days.

1. Falling asleep:
   - 0 I never take longer than 30 minutes to fall asleep.
   - 1 I take at least 30 minutes to fall asleep, less than half the time.
   - 2 I take at least 30 minutes to fall asleep, more than half the time.
   - 3 I take more than 60 minutes to fall asleep, more than half the time.
2. Sleep during the night:
   - 0 I do not wake up at night.
   - 1 I have a restless, light sleep with a few brief awakenings each night.
   - 2 I wake up at least once a night, but I go back to sleep easily.
   - 3 I awaken more than once a night and stay awake for 20 minutes or more, more than half the time.
3. Waking up too early:
   - 0 Most of the time, I awaken no more than 30 minutes before I need to get up.
   - 1 More than half the time, I awaken more than 30 minutes before I need to get up.
   - 2 I almost always awaken at least one hour or so before I need to, but I go back to sleep eventually.
   - 3 I awaken at least one hour before I need to, and can't go back to sleep.
4. Sleeping too much:
   - 0 I sleep no longer than 7–8 hours/night, without napping during the day.
   - 1 I sleep no longer than 10 hours in a 24-hour period including naps.
   - 2 I sleep no longer than 12 hours in a 24-hour period including naps.
   - 3 I sleep longer than 12 hours in a 24-hour period including naps.
5. Feeling sad:
   - 0 I do not feel sad.
   - 1 I feel sad less than half the time.
   - 2 I feel sad more than half the time.
   - 3 I feel sad nearly all of the time.
6. Decreased appetite:
   - 0 There is no change in my usual appetite.
   - 1 I eat somewhat less often or lesser amounts of food than usual.
   - 2 I eat much less than usual and only with personal effort.
   - 3 I rarely eat within a 24-hour period, and only with extreme personal effort or when others persuade me to eat.

Please Turn Page -->

Name:_____ Date:_____

QUICK INVENTORY OF DEPRESSIVE SYMPTOMATOLOGY (SELF-REPORT) (QIDS-SR 16)

Please circle the one response to each item that best describes you for the past seven days.

7. Increased appetite:
   - 0 There is no change from my usual appetite.
   - 1 I feel a need to eat more frequently than usual.
   - 2 I regularly eat more often and/or greater amounts of food than usual.
   - 3 I feel driven to overeat both at mealtime and between meals.
8. Decreased weight (within the last two weeks):
   - 0 I have not had a change in my weight.
   - 1 I feel as if I've had a slight weight loss.
   - 2 I have lost 2 pounds or more.
   - 3 I have lost 5 pounds or more.
9. Increased weight (within the last two weeks):
   - 0 I have not had a change in my weight.
   - 1 I feel as if I've had a slight weight gain.
   - 2 I have gained 2 pounds or more.
   - 3 I have gained 5 pounds or more.
10. Concentration/Decision making:
   - 0 There is no change in my usual capacity to concentrate or make decisions.
   - 1 I occasionally feel indecisive or find that my attention wanders.
   - 2 Most of the time, I struggle to focus my attention or to make decisions.
   - 3 I cannot concentrate well enough to read or cannot make even minor decisions.
11. View of myself:
   - 0 I see myself as equally worthwhile and deserving as other people.
   - 1 I am more self-blaming than usual.
   - 2 I largely believe that I cause problems for others.
   - 3 I think almost constantly about major and minor defects in myself.
12. Thoughts of death or suicide:
   - 0 I do not think of suicide or death.
   - 1 I feel that life is empty or wonder if it's worth living.
   - 2 I think of suicide or death several times a week for several minutes.
   - 3 I think of suicide or death several times a day in some detail, or I have made specific plans for suicide or have actually tried to take my life.

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Name:_____ Date:_____

QUICK INVENTORY OF DEPRESSIVE SYMPTOMATOLOGY (SELF-REPORT) (QIDS-SR 16)

Please circle the one response to each item that best describes you for the past seven days.

13. General interest:
    - 0 There is no change from usual in how interested I am in other people or activities.
    - 1 I notice that I am less interested in people or activities.
    - 2 I find I have interest in only one or two of my formerly pursued activities.
    - 3 I have virtually no interest in formerly pursued activities.

14. Energy level:
    - 0 There is no change in my usual level of energy.
    - 1 I get tired more easily than usual.
    - 2 I have to make a big effort to start or finish my usual daily activities (for example, shopping, homework, cooking or going to work).
    - 3 I really cannot carry out most of my usual daily activities because I just don't have the energy.

15. Feeling slowed down:
    - 0 I think, speak, and move at my usual rate of speed.
    - 1 I find that my thinking is slowed down or my voice sounds dull or flat.
    - 2 It takes me several seconds to respond to most questions and I'm sure my thinking is slowed.
    - 3 I am often unable to respond to questions without extreme effort.

16. Feeling restless:
    - 0 I do not feel restless.
    - 1 I'm often fidgety, wringing my hands, or need to shift how I am sitting.
    - 2 I have impulses to move about and am quite restless.
    - 3 At times, I am unable to stay seated and need to pace around.

Name:_____ Date:_____

Body-Related Behaviors and Concerns

For each applicable question below, please mark an X in the YES or NO column.

Chronic Hair Pulling	YES	NO
1) Have you ever been unable to stop pulling out your hair? (or eyebrows? or eyelashes?) If yes, describe:		
2) Did you end up with a bald spot or noticeable hair loss from your hair pulling?		
If **YES**, please continue below; If **NO**, please go to Nail Biting (item # 9)		
3) What effect has hair pulling had on your life?		
4) Has hair pulling caused you a lot of distress?		
5) Has your hair pulling had any effects on family, friends, or coworkers? If yes, describe:		
6) Do you feel a sense of tension immediately before you carry out the behavior or when you attempt to resist the behavior?		
7) Do you feel a sense of pleasure, relief, or gratification upon completing the behavior?		
8) How old were you when this behavior started? Age of Onset = _____		
Office Use Only: Is this behavior better accounted for by another disorder or general medical condition?		

Nail Biting	YES	NO
9) Have you ever been unable to stop biting your nails?		
If **YES**, please continue below; If **NO**, please go to Skin Picking (item #16)		
10) What effect has nail biting had on your life?		
11) Has nail-biting caused you a lot of distress?		
12) Has your nail biting had any effects on family, friends, or coworkers? If yes, describe:		
13) Do you feel a sense of tension immediately before you carry out the behavior or when you attempt to resist the behavior?		
14) Do you feel a sense of pleasure, relief, or gratification upon completing the behavior?		

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15) How old were you when this behavior started? Age of Onset = _____		
Office Use Only: Is this behavior better accounted for by another disorder or general medical condition?		
Skin Picking	**YES**	**NO**
16) Did you ever pick at your skin excessively?		
17) Did you ever pick at a scab or scar excessively?		
18) Were you unable to stop, even though you tried to?		
If **YES**, continue below; If **NO**, go to Body Dissatisfaction (item #25)		
19) What effect has skin picking had on your life?		
20) Has skin picking caused you a lot of distress?		
21) Has your skin picking had any effects on family, friends, or coworkers? If yes, describe:		
22) Do you feel a sense of tension immediately before you carry out the behavior or when you attempt to resist the behavior?		
23) Does you feel a sense of pleasure, relief, or gratification upon completing the behavior?		
24) How old were you when this behavior started? Age of Onset = _____		
Office Use Only: Is this behavior better accounted for by another disorder or general medical condition?		

Body Dissatisfaction	**YES**	**NO**
25) Have you ever been excessively bothered by something in your appearance?		
26) If yes, how often have you thought about it? In a typical day, approximately how much time would you spend thinking about this aspect of your appearance? For example, at least an hour a day? Describe:		
27) How much has this bothered you? What effect has this had on your life? Has it made it difficult for you to go to work or be with friends? Describe:		
28) How old were you when your concerns with your appearance started? Age of Onset = _____		
Office Use Only: Is preoccupation better accounted for by another disorder?		
Office Use Only: Is preoccupation markedly excessive or unrealistic?		

ASSQ

Name_____ Date_____

		Presently			As a Child		
		No 0	Some-what 2	Yes 3	No 0	Some-what 2	Yes 3
1	Are/were you old-fashioned or precocious?						
2	Are/were you regarded as an 'eccentric professor' by others?						
3	Do/did you live somewhat in a world of you own with restricted idiosyncratic intellectual interests?						
4	Do/did you accumulate facts on certain subjects (good rote memory) without really understanding the meaning?						
5	Do/did you have a literal understanding of ambiguous and metaphoric language?						
6	Do/did you have a deviant style of communication with formal, fussy, 'old-fashioned' or 'robot-like' language?						
7	Do/did you invent idiosyncratic words and expressions?						
8	Do/did you have a different voice or speech?						
9	Do/did you express sounds involuntary; clear your throat, grunt, smack, cry, or scream?						
10	Are/were you surprisingly good at some things and surprisingly poor at others?						
11	Do/did you use language freely but fail to make adjustments to fit social contexts or the needs of different listeners?						
12	Do/did you lack empathy?						
13	Do/did you make naïve and embarrassing remarks?						
14	Do/did you have a deviant style of gaze?						
15	Do did/ you wish to be sociable but fail to make relationships with peers?						
16	Can/could you be with others but only on your terms?						
17	Do/did you lack a best friend?						
18	Do/did you lack common sense?						
19	Are/were you poor at games; have no idea of cooperating in a team; score your 'own goals'?						
20	Do/did you have clumsy, ill coordinated, ungainly, awkward movements or gestures?						
21	Do/did you have involuntary face or body movements?						
22	Do/did you have difficulties in completing simple daily activities because of compulsory repetition of certain actions or thoughts?						
23	Do/did you have special routines or insist on no change?						
24	Do/did you show idiosyncratic attachment to objects?						
25	Are/were you bullied by others?						
26	Do/did you have markedly unusual facial expression?						
27	Do/did you have markedly unusual posture?						