IU School of Medicine Counseling Services
Intake Questionnaire

The purpose of this questionnaire is to obtain a comprehensive picture of your personal background. The information you provide facilitates a more complete evaluation to serve you better. It also allows more efficient use of your time during your scheduled appointment. Please answer the questions as thoroughly and accurately as you feel comfortable. All information is confidential. As with all of our records, this information is strictly confidential and will not be released to any person, department, or agency without your prior written consent or as may be required by law.

Name: ____ **Today's Date**: _________________
Last First M.I. Month/Day/Yea r

Partner: ____
Last First M.I.

Children: ____ Age: _______
Last First M.I.

____ Age: _______
Last First M.I.

____ Age: _______
Last First M.I.

Local Address: ____ May we write you there? Yes No
Street Apt.

____
City, State Zip

If applicable, how long have you lived in Indianapolis? _________________

Local Phone: ______________________ Work: ______________________ May we phone you there? Yes No

Pager: ___________________________ Cell: ________________________ May we page/phone you there? Yes No

E-mail Address: ____ May we e-mail you there? Yes No

Emergency Contact: ____
Last First Relationship Phone No:

Please circle or fill in the appropriate answer (s):
Age: ____ Sex assigned at birth: _____________ Date of Birth: ___________________

Gender (check all that apply) Man_____ Woman_____ Transgender Female to Male _____ Male to Female Other _____ Genderqueer_____ Other _____

Affiliation:
1. 1st Year
2. 2nd Year
3. 3rd Year
4. 4th Year
5. Graduate Student __ Year
6. Resident/Housetaff __Year
   Specialty_____________________
7. Student/Resident: Partner

Religious/Spiritual Practice _____Yes _____No
Ethnic Background_______________________

Do you have a pet: _____Yes_____No

Relationship Status:
1. Divorced; When_______
2. Married; When_______
3. Never Married
4. Partnered; When_______
5. Separated; When_______
6. Widowed; When_______

Living Situation
1. Alone
2. Roommate
3. Spouse/Significant Other
4. Parents

International Student: Yes No

Referral: Who referred you to Counseling Services (or was most influential in your decision to come)?____________

____

Family History

Please circle and fill in the appropriate answer(s):

Father living? Yes No Age ___ Mother living? Yes No Age ____ Spouse/Partner? Yes No Age _____

Occupation:__________________ Occupation: ____________________ Occupation: _____________________

Parents' relationship status __________________ Years in USA _______Mother _________ Father

Number of brothers: ____ Ages: ______ Number of sisters: ____ Ages: ______ Position in birth order __________

Is there any history of psychological problems in your immediate family? _______ Yes _______ No

If yes, please explain: ____

____

____

Is there any history of physical problems in your immediate family? _______ Yes _________ No

If yes, please explain: ____

____

____

Briefly describe yourself: ____

____

____

Personal Mental Health Information

Main purpose for seeking help:____

____

____

____

____

Why are you seeking help at this time and what are your goals for being here?_________________________

____

____

____

How will you know you are successful in achieving your goals?____________________________________

____

____

____

____

How long have these difficulties been bothering you?

________ about 1 week ________ about a month _______ about 1 semester __________ about a year or longer

Overall, how severe are these difficulties?

____________ Mild ___________ Moderate __________ Severe __________ Extremely severe

Please rate the degree to which your problems are impacting you in the following areas:
Because of my problems:

I am sad/depressed	1-Never	2	3	4	5-Most of the time
I am stressed/anxious	1-Never	2	3	4	5-Most of the time
I have eating problems	1-Never	2	3	4	5-Most of the time
I have sleeping difficulties	1-Never	2	3	4	5-Most of the time
I have academic difficulties	1-Never	2	3	4	5-Most of the time
I have problems with friends	1-Never	2	3	4	5-Most of the time
I have problems with family	1-Never	2	3	4	5-Most of the time
I have problems with a romantic relationship	1-Never	2	3	4	5-Most of the time
I have suicidal thoughts	1-Never	2	3	4	5-Most of the time
I have thoughts of harming others	1-Never	2	3	4	5-Most of the time

Prior attemts at solving these problems include:____

____
____
____
____

Previous symptoms throughout your entire life:____

____
____
____
____

Current Life Stresses: (include anything that is stressful to you: relationships, school, work, finances, children)

____
____
____

Describe your Strengths:____

____
____

Do you feel that you are a person of worth or at least equal to others? Very Much Much Somewhat A Little No

What have you done that you are most proud of?____

____

Current Relationship Satisfaction:____

____
____
____
____

On the average, how many hours per week do you spend doing the following:

Work/study/go to class___________
Household chores, bills, etc.___________
Leisure activities___________
Social activities___________
Church, charity, spiritual or inspiration activities___________
Sleep per night___________

Check any of the following which apply to you:

_______ palpitations
_______ dizziness
_______ stomach trouble
_______ fatigue
_______ loss of appetite
_______ increased appetite
_______ difficulty falling asleep
_______ difficulty waking up
_______ sleep too much
_______ nightmares
_______ headaches
_______ bodyaches
_______ restless

_______ recent weight loss
_______ recent weight gain
_______ physically healthy
_______ sexual dysfunction concerns
_______ some alcohol use
_______ too much alcohol use
_______ some drug use
_______ too much drug use

_______ depressed
_______ no interest in school
_______ no interest in activities
_______ no interest in socializing
_______ worthwhile
_______ worthless
_______ guilty
_______ naive
_______ irritable
_______ intentionally harming self
_______ loss of motivation
_______ difficulty with decisions
_______ horrible thoughts
_______ life feels empty
_______ lonely
_______ sympathetic toward others
_______ inadequate
_______ incompetent

_______ family separation
_______ family divorce
_______ family alcohol use
_______ family drug use
_______ physical abuse by family member
_______ physical abuse by relative
_______ physical abuse by other person
_______ stressed
_______ concentration problems
_______ memory problems

_______ academic difficulties
_______ career concerns
_______ confused
_______ intelligent
_______ organized
_______ lack self confidence
_______ poor study skills
_______ poor organization
_______ poor time management
_______ bored

_______ relationship concerns
_______ problems relating to same sex
_______ problems relating to other sex
_______ personable and friendly
_______ sexual orientation concerns
_______ sexual decision making concerns
_______ concerns about a friend
_______ concerns about a family member

_______ anxious
_______ worry about a lot of things
_______ feel panicky
_______ calm
_______ fearful
_______ aggressive
_______ talkative
_______ thinking constantly
_______ risky behavior
_______ dangerous behavior
_______ energetic
_______ distracted easily

_______ repeated thought about one thing
_______ engage in one behavior repeated
_______ anorexia
_______ bulimia
_______ excessive exercise

_______ sexual harassment
_______ acquaintance rape
_______ other sexual coercion
_______ physical harassment
_______ childhood sexual abuse
_______ childhood emotional abuse
_______ experience of a traumatic event

Any other difficulties:_____________________________
____
____
____

Anxiety Manifestations

Circle all symptoms that you notice either currently or in the past; designate *frequency*.

Tension in thumbs	
Tension around/in mouth	
Blinking	
Clenching fist	
Moving forearms (over)	
Upper arm tension	
Shoulders tension	
Neck tension	
Facial tension	
Vocal cords-tightness in throat	
Abdominal wall tension	
Sighing	
Intercostal muscular tension	
Back muscular tension	
Leg tension	
Feet/Toes tension	
Tension headaches	

Autonomic & Endocrine Patterns: Circle all symptoms that you notice either currently or in the past; designate *frequency*.

Sympathetic:	
Dry: mouth, throat, eyes	
Sweating: armpits, palms	
Salivation	
Cold hands, shivering	
Increased: heart rate, blood pressure, blushing, breath shortness; palpitations	
GI tract: nausea, vomiting, diarrhea	
All mucous is dry	
Shakiness, trembling	
Parasympathetic:	
Salivation, teary eyes	
Decreased: heart rate, blood pressure, arrhythymia	
GI tract: ulcer, reflux, nausea, vomiting, diarrhea, constipation	
Flip-flop or stomach butterlies	
Irritable bowl	
Frequent urge to urinate	
Lightheadedness	
Dizziness	
Limp feeling	
Fainting	
Body anaesthesia or tingling	
Migraines due to vasodilation	
Asthma	
Jelly legs	

Cognitive-perceptual patterns: Circle all symptoms that you notice either currently or in the past; designate frequency.

Thought Processes: Incoherent, Chaotic, Drifting, Delayed, Empty headed, Accelerated, Confusion, Losing track of thoughts, Poor memory	
Thought Content: Disturbed orientation: to time, place, persons	
Perception: Visual acuity: Hazy view, Blurring, Tunnel, Loss of vision	
Auditory perception: Tinnitus, Hallucinations	
Dissociation, Detached, Unreal, Numbness, No contact with arms, legs, etc., Fainting, Freezing, Loss of identity, memories, personality	

Velocity of Rise and Fall and Duration of Anxiety Manifestations & Anxiety-regulating Capacity

Anxiety Regulation Capacity					
++	+	+/-	-	--	---
Velocity of Rise					
Very slow	Slow	Med-ium	Fast	Mod. fast	Very fast
Duration					
<15 mins	<30 mins	<60 mins	>15 mins	>30 mins	>60 mins
Velocity of Fall					
Very fast	Fast	Med-ium	Slow	Very slow	Ext. slow

Past Mental Health History:

Please list the mental health professionals you have seen in the past (psychiatrists, psychologists, social workers, therapists, counselors, etc.)

Name: Location: Dates: Reason:

____
____
____

Please list any past psychiatric hospitalizations/partial programs you have been admitted:

Hospital Date (s) Reason for treatment

____
____
____
____

Please list any psychiatric medications you have taken in the past:

Medication Dose Date (s) Medication Response Prescribing Physcian

____
____
____

List all medications you are currently taking, when you take it and why you take it:

Medication Dose Date (s) Medication Response Prescribing Physcian

____
____
____

Alcohol and Substance Use History:

Have you ever been diagnosed with or treated for, a substance use problem? _____ Yes _____ No

If so, where and when? ____
____
____

Please describe your alcohol use:

Type of Alcohol Amount How Often

____
____
____

Please list any current or past use of other types of drugs:

Drug Amount Used How Often Last Used

____
____
____

Do you or have you ever experienced withdrawal symptoms from alcohol or drugs?________________________

Has anyone told you they thought you had a problem with drugs or alcohol?___________________________

Have you ever felt guilty about your drug or alcohol use?____

Have you ever used drugs or alcohol first thing in the morning?_____________________________________

Legal History

Have you ever been arrested or convicted of a crime? Yes ____ No ____

If so, when, where and for what: ____

Childhood History

Tell us about yourself. Some things you can include are: birthplace and home; how often did you move? Where did you attend college, medical school (if applicable) and residency; noteworthy experiences.

____
____
____
____
____
____

Please briefly describe your relationship with your family of origin?

____
____
____
____

In the space below, please indicate if there are any issues from your childhood or adolescence which you think may be of significance (e.g. childhood illness, school problems, parents' divorce, family conflict, etc.).

____
____
____
____
____
____

Sexual history:

Age at the time of first sexual experience:____________________ Number of sexual partners:____________

Any history of sexually transmitted disease?__________________ History of terminated pregnacy?_______

Any history of sexual abuse, molestation or rape?____

Sexual orientation?______________ Currently sexually active?__________

Current sexual problems?_________Is so, please describe.____

____
____
____

Any history of physical abuse? Is so, please describe.______________________________________

____
____
____

What is your earliest childhood memory?

____
____
____

When was the worst time of your life? Who helped you through it?

____
____
____

When was the best time of your life?

____
____

Do you have someone in whom you confide? Yes No

Have you developed at least 1 or 2 friendships here? Yes No

What are your hobbies and what do you do for recreation?____
____

General Physical Health

1. Excellent ____ 2. Good ____ 3. Fair ____ 4. Poor ____

2. When was your last physical?_____________________

3. What tests were administered?______________________________ Results? _________________________________
____
____

Please list any current or ongoing medical conditions for which you are being treated: _______________________________
____
____

List the names, specialty, address, phone and fax numbers of any doctors you are currently seeing:
____
____
____

List any allergies or medication intolerances:
____
____
____

List any surgerical procedures:

Surgery	Hospital	Date	Reason

List any other hospitalizations:

Reason	Date	Place

Any history of head trauma? (describe)
____
____
____

Any seizure or seizure like activity? (describe)
____
____
____

Sleep behavior: (circle all that apply) sleepwalking, nightmares, recurrent dreams, getting up, going to bed, staying asleep, early morning wakeup?

Do you consume caffeine? ____ Yes ____ No If yes, how much per day? ____________ Container size? ___

Do you consume energy drinks? ____ Yes ____ No If yes, how much per day? ____________ Container size? ___

Do you use tobacco? ____Yes ____ No If yes, how much per day? ____________________________________

Do you exercise? ____ Yes ____ No If yes, how often and what type of exercise______________________________

Do you take supplements? ____ Yes ____No If yes, please list: ____

SELF-ASSESSMENT OF FUNCTIONING: Please rate (from 1-10) how well you feel you are currently functioning in each of the three areas listed below, according the following scale:

10 ----------9 ------------- 8 ----------7-------- 6 -------- 5 -------- 4------------3 ---------- 2 ----------- 1
Excellent Functioning Mild difficulty Moderate difficulty Severe Difficulty Barely able to function

1. General Mood (Depression, Anxiety, etc.) _____ 2. Social Relationships? _____ 3. Daily work or school?____

In the last month has there been a period of time (of 2 weeks or more) when you were feeling depressed or down most of the day nearly every day? .... No Yes
Have you felt a lot less interested in things or unable to enjoy the things you used to enjoy? (Was it most of the day nearly every day for at least two weeks?) .... No Yes

DYS
For two years or more, have you been bothered by depressed mood most of the day, more days than not? .... No Yes
Have you felt any of the following? Please check:
Pronounced weight loss or weight gain .... _____ Difficulty concentrating/indecisive .... _____
Sleeping too much or too little .... _____ Recurrent thoughts of death, dying or hurting self_____

Fidgety/Agitated or restless behavior .... _____ Making a plan for suicide .... _____
Feeling slowed down, sluggish .... _____ Taking some action toward suicide ... _____
Feelings of worthlessness or excessive guilt .... _____ Fatigue or loss of energy .... _____

PMD
Have you ever before had a 2 week period when you were feeling depressed or down more days than not? .... No Yes

MN
In the last month, has there been a period of time when you were feeling so good, high, excited or hyper that other people thought you were not your normal self or you got into trouble? (Did anyone say you were manic? Was that more than just feeling good?) .... No Yes
Has there been a period of time when you felt so irritable that you shouted at people or started fights/arguments? .. No Yes

PMN
Have you ever had a time when you were feelings so good or hyper that other people thought you were not your normal self or you were so hyper that you got into trouble: (Did anyone say you were manic, then?) .... No Yes

DEL
Have you had any unusual experiences, for example did it ever seem like people were talking about you or taking special notice of you? .... No Yes
What about receiving special messages from people or from the way things were arranged around you, or from the newspaper, radio, or TV? .... No Yes

SCH
Other than when you were depressed or feeling high, has there been a time when you heard voices, had visions, or saw or smelled things that others couldn't see or smell? .... No Yes
Or did you do something to call attention to yourself like dressing in some odd way or doing something strange? . No Yes

ALC
Was there ever a period in you life when you drank too much? (Has alcohol ever caused problems for you?) …..... No Yes
Has anyone ever objected to your drinking - or a doctor told you to stop drinking? .... No Yes
Have you gone 'on the wagon' or ever tried to cut down on your drinking? .... No Yes

DRG
Have you used any street drugs, or used prescription drugs in an amount or way that wasn't prescribed? .... No Yes
If street drug: Has there ever been a time when you took it at least ten times in a one month period of time? .... No Yes
If prescribed: Did you ever get hooked/dependent? .... No Yes

PAN
Have you ever had a panic attack, when you felt frightened, anxious, uncomfortable, worried about going crazy or suddenly developed a lot of physical symptoms (e.g., heart-pounding, trembling, dizziness)? .... No Yes
If yes, has the panic attack been followed by persistent concern about having additional attacks, worry about the implications or consequences of the attack, or a significant change in behavior related to the attacks? .... No Yes

OC
Have you ever been bothered by thoughts**,** impulses or images that caused anxiety and kept coming back even when you tried not to have them? .... No Yes
What about awful thoughts, like hurting someone against your will, or being contaminated by germs or dirt? ....No Yes
Was there ever anything that you had to do over and over again and couldn't resist doing, like washing your hands again and again, counting up to a certain number or checking something several times to make sure you'd done it right? .... .No Yes

PTSD
Is there a traumatic event or memory that keeps coming back in nightmares, flashbacks or thoughts—that you can't put out of your mind, & which continues to cause you great distress? .... .No Yes

AGR
Have you been afraid of leaving the house alone, being in crowds, standing in line, or traveling on buses or trains? .... .No Yes
Have you felt any of the following? Please check:
Pounding, racing heart . ___ Chest pain or discomfort .. ___ Fear of losing control, going crazy ___
Sweating .... ___ Nausea/abdominal distress___ Fear of dying .... ___
Trembling, shaking ...... ___ Dizzy, lightheaded or faint___ Numbness or tingling sensation ... ___
Shortness of breath ...... ___ Feelings of unreality or Chills or hot flushes .... ___
Feelings of choking ...... ___ detached from oneself .. ___

SOC
Is there anything that you were ever afraid of or uncomfortable doing in front of other people like speaking, eating or writing? .... No Yes

PHB
Are there any other things that you have been especially afraid of such as flying, snakes, seeing blood, getting a shot, heights, closed places or certain kinds of animals or insects? ….. No Yes

GAD
In the last six months, have you been particularly nervous or anxious? .... No Yes
Do you worry a lot about terrible things that might happen? .... No Yes
Have you felt any of the following? Please check:

Restlessness or feeling keyed up or on edge .... _____ Irritability .... _____
Being easily fatigued .... _____ Muscle tension .... _____
Difficulty concentrating or mind going blank .... _____ Difficulty sleeping or restless sleep ... _____

SM/HY

Over the last several years, have you had to go to the doctor often because you weren't feeling well? .... No Yes
Have you worried that something was wrong, even when a doctor told you there was nothing the matter? .... No Yes

ANO

Have you ever had a time when you weighed much less than other people thought you ought to weigh? .... No Yes
At that time were you very afraid that you could become fat? .... No Yes

BUL

Have you often had times when your eating was out of control? .... No Yes
Have you ever made yourself throw-up, used laxatives or exercised a lot to prevent weight gain? .... No Yes

ADD

Have you had trouble concentrating on things or paying attention for at least 6 months? .... .No Yes
Have you had symptoms of hyperactivity, impulsivity, or restlessness that has persisted for at least 6 months? .. No Yes

AVD

1. Have you avoided jobs or tasks that involved having to deal with a lot of people? .... No Yes
2. Do you avoid getting involved with people unless you are certain they will like you? .... No Yes
3. Do you find it hard to be "open" even with people you are close to? .... No Yes

4. Do you often worry about being criticized or rejected in social situations? .... No Yes
5. Are you usually quiet when you meet new people? .... No Yes
6. Do you believe that you're not as good, as smart, or as attractive as most other people? .... No Yes
7. Are you afraid to try new things? .... No Yes

DEP

8. Do you need a lot of advice or reassurance from others before you can make everyday decisions? .... No Yes
9. Do you depend on other people to handle important areas in your life such as finances, child care or living arrangements? .... No Yes
10. Do you find it hard to disagree with people even when you think they are wrong? .... No Yes
11. Do you find it hard to start work on tasks when there is no one to help you? .... No Yes

12. Have you often volunteered to do things that are unpleasant? .... .No Yes
13. Do you usually feel uncomfortable when you are by yourself? .... No Yes
14. When a close relationship ends, do you quickly need to find someone else you can rely on? .... No Yes
15. Do you worry a lot about being left alone to take care of yourself? .... No Yes

OC

16. Are you the kind of person who focuses on details, order, organization or likes to make lists and schedules? .. No Yes
17. Do you have trouble finishing jobs because you spend so much time trying to get things exactly right? .... No Yes
18. Do you (or others) feel that you are so devoted to work (school) that you have no time for others or for fun? .. No Yes
19. Do you have very high standards about what is right and what is wrong? .... No Yes

20. Do you have trouble throwing things out because they might come in handy someday? .... No Yes
21. Is it hard for you to let other people help you unless they agree to do things exactly the way you want? .... No Yes
22. Is it hard for you to spend money on yourself and other people even when you have enough? .... No Yes
23. Are you often so sure you are right that it doesn't matter what other people say? .... No Yes
24. Have other people told you that you are stubborn or rigid? .... No Yes

NEG

25. When someone asks you to do something that you don't want to do, do you then work slowly or do a poor job?.. No Yes
26. Often, if you don't want to do something, do you just 'forget" to do it? .... No Yes
27. Do you often feel that other people don't understand you, or don't appreciate how much you do? .... .No Yes
28. Are you often grumpy and likely to get into arguments? .... No Yes
29. Have you found that most of your bosses, teachers, doctors, and others who are supposed to know what they are doing, really don't? .... .No Yes
30. Do you often think that it's not fair that other people have more than you do? .... No Yes
31. Do you often complain that more than your share of bad things have happened to you? .... No Yes
32. Do you angrily refuse to do what others want and then later feel bad and apologize? .... No Yes

DPR

33. Do you usually feel unhappy or like life is no fun? .... No Yes
34. Do you believe that you are basically an inadequate person and often don't feel good about yourself? .... No Yes
35. Do you often put yourself down or blame yourself for things that haven't worked out? .... No Yes

36. Are you a worrier? .... No Yes
37. Do you often judge others harshly and easily find fault with them? .... No Yes
38. Do you think that most people are basically no good? .... No Yes
39. Do you almost always expect things to turn out badly? ....No Yes
40. Do you often feel guilty about things you have or haven't done? .... No Yes

SDF

41. Have you repeatedly been involved with friends or lovers who have taken advantage of you or let you down? ….. .... No Yes
42. Have you sometimes gotten into bad situations where you wound up being taken advantage of? .... No Yes
43. Do you often refuse help from other people because you don't want to bother them? .... No Yes
44. When people try to help you, do you find it hard to accept or do you make it hard for them to help you? .... No Yes
45. When you are successful, do you feel depressed or like you don't deserve it, or do something to spoil it? ...... No Yes
46. Do you often turn down the chance to do things that you really enjoy? .... No Yes

PAR

41. Do you often have to keep an eye out to stop people from using you or hurting you? .... No Yes
42. Do you spend a lot of time wondering if you can trust your friends or the people you work with? .... No Yes
43. Do you find that it is best not to confide in others because they will use it against you? .... No Yes

44. Do you often pick up hidden threats or insults in what people say or do? .... No Yes
45. Are you the kind of person who holds grudges or takes a long time to forgive when insulted or slighted? ...... No Yes
46. Are there many people that you can't forgive because they did or said something to you a long time ago? ..... No Yes
47. Do you often get angry or lash out when someone criticizes or insults you in some way? .... No Yes
48. Have you often suspected that your spouse or partner has been unfaithful? .... No Yes

SZD

49. When you are out in public and see people talking, do you often feel that they are talking about you? .... No Yes
50. Do you often feel that things that have no special meaning to most people are really meant to give you a message? ……….. No Yes
51. Do you often detect hidden messages in seemingly unrelated events? .... No Yes
52. Have you ever felt that you could make things happen just by making a wish or thinking about them? .... No Yes
53. Have you had personal experiences with the supernatural? .... No Yes

54. Do you believe that you have a 'sixth sense' that allows you to know or predict things that others can't? ...... No Yes
55. Do you often think that objects or shadow are really people or animals or that noises are actually voices? ..... No Yes
56. Have you had the sense that some person or force is around you, even though you cannot see anyone? .... No Yes
57. Do you often see auras or energy fields around people? .... No Yes

58. Are there very few people that you are really close to outside of your immediate family? .... No Yes
59. Do you often feel nervous when you are with other people? .... No Yes

STP
60. Is it NOT important to you whether you have any close relationships, including being part of a family? .... No Yes
61. Would you almost always rather do things alone than with other people? .... No Yes
62. Could you be content without ever being sexually involved with another person? .... No Yes
63. Are there really very few things that give you a lot of pleasure? .... No Yes
64. Does it not matter to you what people think of you? .... No Yes
65. Do you find that nothing makes you very happy or very sad? .... No Yes

HIS
66. Are you uncomfortable if you are not the center of attention? .... No Yes
67. Do you flirt a lot? .... No Yes
68. Do you often find yourself "coming on" to people? .... No Yes
69. Do you try to draw attention to yourself by the way you dress or look? .... No Yes
70. Do you often make a point of being dramatic and colorful? .... No Yes
71. Do you often change your mind about things (opinions) depending on the people you're with or what you have just read or seen on TV? .... No Yes
72. Do you have lots of friends that you are very close to? .... No Yes

NAR
73. Do most people fail to appreciate your very special talents or accomplishments? .... No Yes
74. Have people told you that you have too high an opinion of yourself? .... No Yes
75. Do you think a lot about the power, fame, or recognition that will be yours someday? .... No Yes

76. Do you think a lot about the perfect romance that will be yours someday? .... No Yes
77. When you have a problem, do you almost always insist on seeing the top person? .... No Yes
78. Do you feel it's important to spend time with people who are special or influential? .... No Yes
79. Is it very important to you that people pay attention to you or admire you in some way? .... No Yes
80. Do you think that it's not necessary to follow certain rules or social conventions when they get in your way? .... No Yes

81. Do you feel that you are the kind of person who deserves special treatment? .... No Yes
82. Do you often find it necessary to step on a few toes to get what you want? .... No Yes
83. Do you often have to put your needs above other people's? .... No Yes
84. Do you often expect other people to do what you ask without question because of who you are? .... No Yes

85. Are you NOT really interested in other people's problems or feelings? .... No Yes
86. Are you often envious of others? .... No Yes
87. Do you feel that others are often envious of you? .... No Yes
88. Do you find that very few people are worth your time and attention? .... No Yes

BOR
89. Have you often become frantic when you thought that someone you really care about was going to leave you?... No Yes
90. Do your relationships with people you really care about have a lot of extreme ups and downs? .... No Yes
91. Have you abruptly changed your sense of who you are and where you are headed? .... No Yes

92. Does your sense of who you are often change dramatically? .... No Yes
93. Have there been lots of sudden changes in your goals, career plans, religious beliefs, and so on? .... No Yes
94. Have you often done things impulsively (e.g., spending, sex, reckless driving)? .... No Yes
95. Have you tried to hurt or kill yourself or threatened to do so? .... No Yes

96. Have you ever cut, burned or scratched yourself on purpose? .... No Yes
97. Are you a 'moody' person? .... No Yes

98. Do you often feel empty inside? .... No Yes

99. Do you often have temper outbursts or get so angry that you lose control? .... No Yes
100. Do you hit people or throw things when you get angry? .... No Yes
101. Do even little things get you very angry? .... No Yes
102. When you are under a lot of stress, do you get suspicious of other people or feel especially spaced out? ...... No Yes

ANT

BEFORE THE AGE OF 15 DID YOU EVER DO ANY OF THE FOLLOWING:

103. Did you bully or threaten other kids? .... No Yes
104. Did you start fights? .... No Yes
105. Did you hurt or threaten someone with a bat, brick, broken bottle, knife or a gun? .... No Yes
106. Did you ever deliberately try to cause someone physical pain and suffering? .... No Yes
107. Did you torture or hurt animals on purpose? .... No Yes
108. Did you ever rob, mug or forcibly take something from someone by threatening him or her? .... No Yes
109. Did you ever force someone to have sex with you? .... No Yes
110. Did you set fires? .... No Yes
111. Did you deliberately destroy things that weren't yours? .... No Yes

112. Did you ever break into a house, other buildings, or cars? .... No Yes
113. Did you lie a lot or "con" other people? .... No Yes
114. Did you sometimes steal, shoplift things or forge someone's signature? .... No Yes
115. Did you run away from home and stay away overnight? .... No Yes
116. Would you often stay out very late, long after the time you were supposed to be home? .... No Yes
117. Did you often skip school? .... No Yes
118. Do you own a gun? .... No Yes

VIO

Circle the appropriate response to the questions below. Currently or in the past:

118. How often has someone physically hurt you?	Never	Rarely	Sometimes	Fairly often	Frequently
119. How often has someone insulted or talked down to you?	Never	Rarely	Sometimes	Fairly often	Frequently
120. How often has someone threatened you with harm?	Never	Rarely	Sometimes	Fairly often	Frequently
121. How often has someone screamed or cursed at you?	Never	Rarely	Sometimes	Fairly often	Frequently

Any additional comments/information that you want to include____

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