Intake Questionnaire

You may leave blank anything you prefer not to answer.

Date: _____

Name: _____

Address: _____
Street Address City State Zip Code

Phone Number(s):
Mobile: _____ Messages: __ ok __ discrete only __ not ok
Home: _____ Messages: __ ok __ discrete only __ not ok
Work: _____ Messages: __ ok __ discrete only __ not ok

Date of birth: _____ Age: _____

How do you describe your **gender**? (Circle all that apply)
female male non-binary transgender cisgender genderqueer _____

What **pronouns** should we use to refer to you? (Circle/write)
she/her/her he/his/him they/their/them xe/xyr/xem _____

How do you describe your **race/ethnicity**? (Circle/write)
White Hispanic Native American/Alaskan Native Asian
Pacific Islander Black/African-American _____

First Language: _____

How do you describe your **relationship status**? (Circle/write)
single, never married married living with romantic partner(s)
divorced/separated widowed _____

Number of **Children**: ___ biological ___ adopted ___ step

Highest level of **education**:
___ Grammar or middle-school
___ Some high school
___ High school graduate or equivalent
___ Some college
___ 2-year college degree
___ 4-year college degree
___ Professional/graduate degree

Occupation (most recent if not currently working): _____

Current **work status**: ___ Employed full-time ___ Employed part-time ___ Medically disabled
___ Student ___ Unemployed ___ Retired

Are you (check all that apply):
___ On probation or parole ___ Applying for social security disability
___ Court-ordered to treatment or classes ___ Involved in a dispute over custody of children

How did you hear about the Sutherland Bipolar Center (who referred you to us)?

Why are you seeking services from us (what are your goals, what would you like to gain, why now…)?
1.

2.

3.

4.

5.

HEALTH, HEALTH-RELATED BEHAVIORS, & TREATMENTS

Current and/or chronic non-psychiatric medical conditions (e.g., hypothyroidism; high blood pressure):

Date of last physical examination: _____

Are you an established patient of a physician or clinic? That is, is there someone you can see if you become ill or have a physical injury, or for preventive care?

If yes, please include the name and contact information of the doctor/clinic:

What are your current **exercise** habits?

How would you describe your **diet/nutrition**? (Circle all that apply; add notes as desired)

Balanced Nutritious Adequate Underfed Frequently hungry A lot of "junk" food

Vegetarian Vegan Gluten-free Dairy-free Low-sugar/carb Low-fat Paleo

How would you describe your **sleep?** Include how many hours you get in a typical 24-hour day.

Have you ever had a concussion or lost consciousness? Please describe (include age/year if known):

What mood-altering **substances** do you *currently* use?

	How often? (e.g., daily, 3 times/week, 1/month)	How much? (e.g., 1 pack; 6 beers)
Cigarettes		
Other tobacco/nicotine		
Alcohol		
Caffeine (tea, soda, coffee, energy drinks)		
Other drugs (specify, e.g., marijuana, cocaine, LSD, mushrooms)		

CURRENT psychiatric and non-psychiatric **medications** (prescription, over the counter, & herbal):

Name	Dose	Why taking it?	Name	Dose	Why taking it?
Sample	*20 mg*	*Ulcer*			

Who is *currently* prescribing your psychiatric medications (if any)?
Name: _____ Type of doctor _____Phone: _____

Current Psychotherapist: _____Phone: _____

Other *Current* Treatment Providers: _____ Phone: _____

Current Support/Therapy Groups: _____

Past Psychiatric Hospitalizations (list *when*, *where*, and *why*):

Past Psychotherapy/Counseling Experiences (please describe when, what type of therapy, and for what you sought help):

Past Psychiatric Medications (other than those listed above as current):

Other *past* psychiatric treatments (e.g. ECT; rTMS; residential treatment):

PROBLEMS & SYMPTOMS

Which of the following are you **CURRENTLY** experiencing (check all that apply):

___ Depression
___ Sleep problems
___ Nightmares
___ Fatigue/low energy
___ Loneliness
___ Difficulty concentrating
___ Suicidal ideas
___ Violent ideas
___ Feel panicky
___ Think someone is trying to control my mind
___ Intense anger/rage
___ Eating problems
___ Inferiority feelings
___ Hypomania/mania
___ Racing thoughts
___ Sex-related problems
___ Often feel guilty
___ Feel tense
___ Attention problems
___ Relationship problems
___ Difficulty making friends
___ Difficulty making decisions
___ Unhappy with job
___ Can't keep a job
___ Financial problems
___ Unable to have a good time
___ Legal Problems
___ Hear voices others don't hear
___ Preoccupation with certain thoughts

Have you **EVER**… (Check all that apply)

____1. …intentionally harmed yourself (with or without the intention of killing yourself)?
____2. …been physically or sexually assaulted?
____3. …received special messages from the TV, radio, newspaper or the way things around you were arranged?
____4. …thought you had special powers to do things other people cannot do?
____5. …felt that something was very wrong with you physically even though your doctor said nothing was wrong—like that you had cancer or some other terrible disease?
____6. …had any unusual religious experiences (unusual for your religious culture)?
____7. …felt you committed a crime or did something terrible for which you should be punished?
____8. …heard things other people couldn't hear, such as noises, or the voices of people whispering or talking?
____9. …had visions or seen things other people couldn't see?

Depression

Have you experienced distinct periods of depression, lasting *at least 2 weeks*? ___Yes ___No

Which symptoms have you experienced *when depressed*? (check all that apply)
___ Feel sad, blue, or down in the dumps
___ Lose interest and/or can't take pleasure in things
___ Significant change in appetite (increase or decrease) and/or significant weight gain or loss
___ Get too little sleep (insomnia), or sleep too much (hypersomnia)
___ Feel slowed down in my movements, or very fidgety and restless
___ Feel fatigued or low in energy
___ Feel worthless, and/or very guilty about things
___ Am unable to concentrate, and/or have trouble making even small decisions
___ Think about death and/or killing myself, or made plans or took actions to kill myself

How many *separate times* have you had a period of *two weeks or more* when you experienced 5 or more of the above symptoms at the same time: _____

List the approximate dates of these depressive episodes: _____

Mania/Hypomania

Have you ever had a time when you were not your usual self, and your *mood was very high* (elevated, expansive, euphoric) *or very irritable*? ___Yes ___No

If yes, which of the following have you experienced *when feeling this way*? (check all that apply)
___ Feel much more self-confident than usual
___ Get much less sleep than usual and still feel rested
___ Am much more talkative than usual, or speak much faster than usual
___ Have thoughts racing through my head, or can't slow down my mind
___ Am so easily distracted by things around me that I have trouble focusing or staying on track
___ Have much more energy than usual
___ Am much more active, or do many more things (activities, projects) than usual
___ Am much more social or outgoing than usual, for example, telephoning friends in the middle of the night
___ Am much more interested in sex than usual
___ Do things that are unusual for me or that other people might think are excessive, foolish, or risky
___ Spend excessive money that gets me or my family into trouble

How many *separate times* have you had a period of *4 days or more* when you experienced high or irritable mood, and had 3 or more of the above symptoms at the same time: _____

List the approximate dates of these manic/hypomanic episodes: _____

Has a health professional diagnosed you with a mood disorder? No Yes

IF YES: When were you first diagnosed? _____

What is your current diagnosis? _____

Is there anything else you would like to share in writing?

The Quick Inventory of Depressive Symptomatology (16-Item) (Self-Report) (QIDS-SR16)

Name or ID: _____ Date: _____

CHECK THE ONE RESPONSE TO EACH ITEM THAT BEST DESCRIBES YOU FOR THE PAST SEVEN DAYS.

During 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.

During the past seven days...

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.

Please complete either 6 or 7 (not both)

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.

- OR -

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.

Please complete either 8 or 9 (not both)

8. Decreased Weight (Within the Last Two Weeks):

☐ 0 I have not had a change in my weight.

☐ 1 I feel as if I have had a slight weight loss.

☐ 2 I have lost 2 pounds or more.

☐ 3 I have lost 5 pounds or more.

- OR -

9. Increased Weight (Within the Last Two Weeks):

☐ 0 I have not had a change in my weight.

☐ 1 I feel as if I have had a slight weight gain.

☐ 2 I have gained 2 pounds or more.

☐ 3 I have gained 5 pounds or more.

The Quick Inventory of Depressive Symptomatology (16-Item) (Self-Report) (QIDS-SR16)

During the past seven days...

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.

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.

During the past seven days...

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 _____

ASRM Scale

Instructions:

1. On this questionnaire are groups of 5 statements; read each group of statements carefully.
2. Choose the one statement in each group that best describes the way you have been feeling **for the past week**.
3. Circle the number next to the statement you picked.
4. Please note: The word "occasionally" when used here means once or twice; "often" means several times or more; "frequently" means most of the time.

1] 0 I do not feel happier or more cheerful than usual.
1 I occasionally feel happier or more cheerful than usual.
2 I often feel happier or more cheerful than usual.
3 I feel happier or more cheerful than usual most of the time.
4 I feel happier or more cheerful than usual all of the time.

2] 0 I do not feel more self-confident than usual.
1 I occasionally feel more self-confident than usual.
2 I often feel more self-confident than usual.
3 I feel more self-confident than usual most of the time.
4 I feel extremely self-confident all of the time.

3] 0 I do not need less sleep than usual.
1 I occasionally need less sleep than usual.
2 I often need less sleep than usual.
3 I frequently need less sleep than usual.
4 I can go all day and night without any sleep and still not feel tired.

4] 0 I do not talk more than usual.
1 I occasionally talk more than usual.
2 I often talk more than usual.
3 I frequently talk more than usual.
4 I talk constantly and cannot be interrupted.

5] 0 I have not been more active (either socially, sexually, at work, home, or school) than usual.
1 I have occasionally been more active than usual.
2 I have often been more active than usual.
3 I have frequently been more active than usual.
4 I am constantly active or on the go all the time.

Altman et al. (1997). Biological Psychiatry, 42, 948-955.

DASS21

Name: ***Date:***

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you *over the past week*. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

0 Did not apply to me at all
1 Applied to me to some degree, or some of the time
2 Applied to me to a considerable degree, or a good part of time
3 Applied to me very much, or most of the time

1	I found it hard to wind down	0	1	2	3
2	I was aware of dryness of my mouth	0	1	2	3
3	I couldn't seem to experience any positive feeling at all	0	1	2	3
4	I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5	I found it difficult to work up the initiative to do things	0	1	2	3
6	I tended to over-react to situations	0	1	2	3
7	I experienced trembling (eg, in the hands)	0	1	2	3
8	I felt that I was using a lot of nervous energy	0	1	2	3
9	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
10	I felt that I had nothing to look forward to	0	1	2	3
11	I found myself getting agitated	0	1	2	3
12	I found it difficult to relax	0	1	2	3
13	I felt down-hearted and blue	0	1	2	3
14	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
15	I felt I was close to panic	0	1	2	3
16	I was unable to become enthusiastic about anything	0	1	2	3
17	I felt I wasn't worth much as a person	0	1	2	3
18	I felt that I was rather touchy	0	1	2	3
19	I was aware of the action of my heart in the absence of physical exertion (eg, sense of heart rate increase, heart missing a beat)	0	1	2	3
20	I felt scared without any good reason	0	1	2	3
21	I felt that life was meaningless	0	1	2	3
22	I thought about death or suicide	0	1	2	3
23	I wanted to kill myself	0	1	2	3

FSI Scale

Name: ***Date:***

This questionnaire asks you to rate various areas of life regarding how well you have functioned during **the last month**. Please answer every question.

1. **WORK/SCHOOL is your job, schoolwork, or other responsibility (e.g., homemaking, caregiving, or volunteer work). If you have more than one of these responsibilities, please include them all in your ratings.**

   How well have you **functioned** at WORK/SCHOOL **during the last month**? Functioning refers to how well you are getting things done, including whether you attend regularly, are punctual, meet deadlines, and get along with others.

-4	-3	-2	-1	+1	+2	+3	+4
Extremely Poorly	Very Poorly	Somewhat Poorly	A Little Poorly	A Little Well	Somewhat Well	Very Well	Extremely Well

   How many days **during the last month** did the symptoms for which you are seeking treatment cause you to miss WORK/SCHOOL? _____ days

   How many days **during the last month** did you feel so impaired by your symptoms that even though you went to WORK/SCHOOL, your productivity was reduced? _____ days

2. **LOVE RELATIONSHIP refers to an intimate relationship with another person that generally includes a sexual component.**

   How well have you **functioned** in your LOVE RELATIONSHIP **during the last month**? Have you spent time together, communicated well (e.g., without conflict), been physically intimate? If you are not currently in a LOVE RELATIONSHIP, have you been dating or taking the initiative to establish a love relationship?

-4	-3	-2	-1	+1	+2	+3	+4
Extremely Poorly	Very Poorly	Somewhat Poorly	A Little Poorly	A Little Well	Somewhat Well	Very Well	Extremely Well

3. **RELATIONSHIPS WITH RELATIVES refers to all of your relatives, including your parents, grandparents, siblings, step-parents, aunts, uncles, children, and step-children. Include your ex-spouse if you share parenting responsibilities or if you consider that person to be a part of your family now.**

   How well have you **functioned** in your RELATIONSHIPS WITH RELATIVES **during the last month**? Have you spent time with relatives, been mutually supportive, communicated well and without conflict?

-4	-3	-2	-1	+1	+2	+3	+4
Extremely Poorly	Very Poorly	Somewhat Poorly	A Little Poorly	A Little Well	Somewhat Well	Very Well	Extremely Well

4. **FRIENDSHIP refers to the number and quality of relationships you have with people who are not relatives. Friends are people with whom you feel some degree of closeness and share some activities.**

   How well have you **functioned** in your FRIENDSHIPS **during the last month**? Have you spent time with friends, been mutually supportive, communicated well and without conflict?

-4	-3	-2	-1	+1	+2	+3	+4
Extremely Poorly	Very Poorly	Somewhat Poorly	A Little Poorly	A Little Well	Somewhat Well	Very Well	Extremely Well

5. **RECREATION refers to what you do to enjoy yourself or relax, such as watching movies or television, exercising or participating in sports, studying a language, gardening, visiting friends or relatives, or pursuing other hobbies and interests.**

   How well have you **functioned** at RECREATION activities **during the last month**? Have you participated in recreation activities regularly?

-4	-3	-2	-1	+1	+2	+3	+4
Extremely Poorly	Very Poorly	Somewhat Poorly	A Little Poorly	A Little Well	Somewhat Well	Very Well	Extremely Well

6. **HEALTH refers to wellness and freedom from physical and mental illness, pain or disability.**

   How well have you **functioned** in maintaining your HEALTH **during the last month**? Have you eaten a healthy diet, exercised, engaged in healthy behaviors (e.g., safe sex), taken medications as prescribed, gotten the medical care you need?

-4	-3	-2	-1	+1	+2	+3	+4
Extremely Poorly	Very Poorly	Somewhat Poorly	A Little Poorly	A Little Well	Somewhat Well	Very Well	Extremely Well

7. **STANDARD OF LIVING refers to your income, your possessions (e.g., car, home, clothing) and in general the amount of money you have.**

   How well have you **functioned** in maintaining your STANDARD OF LIVING **during the last month**? Have you earned enough money, paid your bills on time, and handled money responsibly without accumulating too much debt?

-4	-3	-2	-1	+1	+2	+3	+4
Extremely Poorly	Very Poorly	Somewhat Poorly	A Little Poorly	A Little Well	Somewhat Well	Very Well	Extremely Well

8. **HOME refers to the physical space in which you live and your neighborhood and community.**

   How well have you **functioned** at maintaining your HOME (keeping it neat and in good repair), keeping good relationships with neighbors (and with roommates, if you have them), participating in neighborhood and community events, **during the last month**?

-4	-3	-2	-1	+1	+2	+3	+4
Extremely Poorly	Very Poorly	Somewhat Poorly	A Little Poorly	A Little Well	Somewhat Well	Very Well	Extremely Well