

Name:

Date:



## NEW CLIENT INFORMATION FORM

**NOTE:** Naturopathic care is only possible when we have a complete picture of you physically, mentally, and emotionally. Therefore, please take the time to carefully and thoroughly complete this health history questionnaire.

Patient Name \_\_\_\_\_ Age \_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: F M

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Daytime Phone \_\_\_\_\_ Ok to leave message? \_\_\_\_\_

Evening Phone \_\_\_\_\_ Ok to leave message? \_\_\_\_\_

Cell Phone \_\_\_\_\_ Ok to leave message ? \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Email Address: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Reason for Visit today? \_\_\_\_\_

Primary Health Concerns: (In order of importance)

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

## Medical History

Allergies: (Medications, Food, Environmental)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please list Past Surgeries and/or Hospitalizations:

- |          |             |
|----------|-------------|
| 1) _____ | Date: _____ |
| 2) _____ | Date: _____ |
| 3) _____ | Date: _____ |
- \_\_\_\_\_

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Name:

Date:

Please list the medications you are currently taking: (with dosage)

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_
- 4) \_\_\_\_\_
- 5) \_\_\_\_\_

Please attach additional sheet if you are taking more than 5 medications

Please list the supplements you are taking: (with dosage)

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_
- 4) \_\_\_\_\_
- 5) \_\_\_\_\_

### Family History

Please list any significant health concerns for the following relatives.

Are you adopted? \_\_\_\_\_

	Age (if alive)	Age (at death)	Health Problems
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
<u>Maternal</u>			
Grandfather	_____	_____	_____
Grandmother	_____	_____	_____
Aunts/Uncles	_____	_____	_____
<u>Paternal</u>			
Grandfather	_____	_____	_____
Grandmother	_____	_____	_____
Aunts/Uncles	_____	_____	_____

Name:

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### Social History

Do you work? Y/N If yes, how many hours per week? \_\_\_\_\_ Please indicate level of job satisfaction on a scale of 1 to 10: \_\_\_\_\_

Are you married or in a long term relationship? Y/N If yes, please indicate level of satisfaction on a scale of 1 to 10: \_\_\_\_\_

How many marriages have you had: \_\_\_\_\_ How many divorces have you had: \_\_\_\_\_

Do you have children? \_\_\_\_\_ If so, how many and what ages: \_\_\_\_\_

### Drug/Alcohol/Tobacco history

Please indicate substances currently used (over the past 6 months), How much at one time, how many times per day/week, age of first use, past use history, length of time used.

Substance	Current	Past	Age	Amount	Frequency	Length
Caffeine						
Alcohol						
Tobacco						
Marijuana						
Pain Killers						
Tranquilizers						
Sleeping pills						
Diet pills						
Steroids						
Methamphetamines						
PCP/LSD/Mushrooms						
Ecstasy						
Cocaine/Crack						
Heroin						

### Mental Health Information

Have you ever been in counseling/therapy before: \_\_\_\_\_ If yes, did you find it helpful or effective?

Have you ever sought alternative treatment for mental health: \_\_\_\_\_ If yes, what type of treatment and did you find it helpful or effective?

Are you currently receiving mental health services: \_\_\_\_\_ If yes, please list name of practitioner and type of service you are receiving:

Have you ever been hospitalized for mental health concerns: \_\_\_\_\_ If yes, list date(s), length of stay, and reason for hospitalization:

Have you ever been diagnosed with a mental illness? If yes, please list illness(es) and date(s) first diagnosed:

Has anyone in your family ever been diagnosed with a mental illness? If yes, please list relationship(s) and diagnosis:

Have you ever or are you currently engaging in self harm? Current: \_\_\_\_\_ Past: \_\_\_\_\_

Have you ever or are you currently contemplating suicide? Current: \_\_\_\_\_ Past: \_\_\_\_\_

Have you ever, or are you currently contemplating harming another person? Current: \_\_\_\_\_ Past: \_\_\_\_\_

Have you ever attempted suicide: \_\_\_\_\_ If yes, please list date(s), method(s), and your age at time of attempt: \_\_\_\_\_

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**Name:**

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Has anyone else in your life ever attempted \_\_\_\_\_ or completed suicide: \_\_\_\_\_

Relationship \_\_\_\_\_

Have you ever been the victim of abuse (verbal, physical, sexual): \_\_\_\_\_ If yes, at what age: \_\_\_\_\_

Please indicate if you are currently experiencing or have recently experienced any of the following symptoms:

Depressed mood	Hearing voices	Loneliness
Suicidal thoughts	Hallucinations	Scary dreams
Angered easily	Delusions	Sleep paralysis
Anxiousness	Racing thoughts	Mental confusion
Restlessness	Decreased need for sleep	Rapid mood swings
Excessive worry	Excessive energy	Frequent crying
Shy/timid	Elated mood	Suspicious/jealous
Delusions of grandeur	Over confidence	Paranoia

### Review of Systems

Please mark "now" or "past" next to all areas that apply to your past and present health.

NOW	PAST	GENERAL SYMPTOMS
		Tired, weak, lack of energy
		Irritability/moodiness
		Worry, anxiety, nervousness
		Sleeplessness, or too much sleep
		Frequent colds
		Dizziness, fainting, black out
		Night sweats/excess sweat
		Anemia
		Headaches
		>10lb Weight Loss/Gain in the last year

NOW	PAST	EYES
		Glasses/contacts
		Blurry vision
		Dry, burning, itchy eyes
		Watery eyes
		Night blindness
		Red or puffy eyes
		Mucus or discharge in eyes
		Pain in eyes

NOW	PAST	EARS
		Earaches
		Noises or ringing in ears
		Discharge
		Loss of hearing
		Excess earwax
		Difficulty hearing

NOW	PAST	CHEST
		Persistent cough
		Spitting up blood or mucous
		Difficulty breathing
		Chest pain
		Wheezing
		Palpitations

NOW	PAST	SKIN & HAIR
		Acne
		Hives or rashes
		Itching skin
		Skin ulcers
		Dryness, roughness, or scaling
		Hair loss or thinning
		Dry, course hair
		Easy bruising
		Nails weak or ridged
		Hangnails
		Warts, moles, skin tags
		Poor wound healing

NOW	PAST	NOSE & THROAT
		Allergies, sinusitis, runny nose
		Nosebleeds
		Dry or chapped lips
		Swollen lymph nodes
		Sore, red, cracked tongue
		Cold sores or Canker sores
		Loss of smell or taste
		Bleeding gums
		Hoarseness or sore throat
		Grinding teeth
		Dental problems
		Difficulty swallowing

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NOW	PAST	<b>GASTROINTESTINAL</b>
		Loss of appetite
		Nausea or vomiting
		Bad breath
		Metallic or bad taste in mouth
		Heartburn
		Indigestion
		Fatigue after eating
		Bloating
		Gas
		Constipation
		Diarrhea
		Light colored stool
		Undigested food in stool
		Floating stool
		Blood or mucous in stool
		Hemorrhoids
		Rectal pain/itching

NOW	PAST	<b>CARDIOVASCULAR</b>
		Heart beats fast or irregular
		Tightness in chest
		Dizziness or weak on standing
		Swollen feet, ankles, or legs
		Cold hands or feet
		Discoloration of hands or feet
		Leg pain walking
		High blood pressure
		Low blood pressure

NOW	PAST	<b>FEMALE</b>
		Irregular periods
		Pain with period
		Mood swings around period
		Painful or swollen breasts
		Lumps in breast
		Nipple discharge
		Vaginal discharge
		Vaginal pain or itching
		Heavy periods
		Hot flashes
		Decreased sex drive
		Difficulty reaching orgasm
		Miscarriages (how many? __)
		Abortions (how many? __)
		Pain with intercourse
		Pelvic pain
		Inability to conceive

NOW	PAST	<b>MUSCULOSKELETAL</b>
		Muscle pain
		Muscle weakness
		Joint pain
		Joint swelling
		Back pain
		Neck pain
		Joint stiffness
		Numbness or tingling
		Restless legs

NOW	PAST	<b>URINARY</b>
		Difficulty urinating
		Frequent urination at night
		Bed wetting
		Incomplete urination
		Incontinence (urine leakage)
		Pain with urination
		Urinary tract infections
		Kidney stones
		Blood in urine

NOW	PAST	<b>MALE</b>
		Prostate enlargement/pain
		Erectile dysfunction
		Premature ejaculation
		Decreased libido
		Genital discharge
		Rashes or sores
		Pain in genitals
		Pain in testicles
		Prostate cancer

Name:

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**Terms of Service**

The practice of medicine is regulated at the state level. Unlike many other states, the State of Florida does not currently issue licenses to naturopathic doctors. Though Brooke McNeal, N.D. holds a license to practice naturopathic medicine in the State of California (ND471), she is neither a licensed ND nor licensed healthcare provider in the State of Florida. Therefore, her services in Florida are in a consulting and educational capacity only.

Consultations services are based on published literature pertinent to the client’s health concerns. This information review may include literature on homeopathy, diet, exercise, nutrients, home hydrotherapy, and other resources for self-care. Guidance will be provided to help clients formulate their own health plan, based on their individual needs.

Services provided by Brooke McNeal, N.D. are not a replacement for medical care from a licensed healthcare provider. No medical care including physical exams, diagnostic tests, diagnosis, or treatment will be provided directly by Brooke McNeal, N.D.

**Please Initial and Sign**

\_\_\_\_ I understand that Brooke McNeal, N.D. is *not* a licensed healthcare provider in the State of Florida and her consulting services are *not* a replacement for medical care from a licensed healthcare provider.

\_\_\_\_ I understand that I will *not* be receiving medical care, lab tests, diagnosis, treatment, or physical exams from Brooke McNeal, N.D.

\_\_\_\_ I understand that payment is expected at the time of service and rates are listed below.

\_\_\_\_ I understand that Brooke McNeal, N.D. does not accept insurance.

\_\_\_\_ I understand the privacy practices of this office (see confidentiality statement below), required by HIPAA, and have had the opportunity to read them if I wish.

Patient or Responsible Party Signature \_\_\_\_\_ Date \_\_\_\_\_

**Fees for Service**

**A La carte services**

New client consult - \$500

Follow up consultation - \$100

**Wellness packages**

Package 1: New client consultation +5 follow up consultations - \$900 (10% discount)

Package 2: New client consultation + 10 follow up consultations - \$1,275 (15% discount)

Package 3: New client consultation + 15 follow up consultations - \$1,600 (20% discount)

Package 4: New client consultation + 20 follow up consultations - \$1,875 (25% discount)

Package 5: New client consultation + 25 follow up consultations - \$2,100 (30% discount)

**Follow up packages**

10 follow ups - \$850 (15% discount)

20 follow ups - \$1,500 (25% discount)

30 follow ups - \$1,950 (35% discount)

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Name:

Date:

### Payment Agreement

Please read the following agreement. It explains your financial obligations while under our care.

Payment is always due at the time of service. We accept the following forms of payment:

- Cash
- Check
- Credit/Debit Card

**We do not accept insurance. Insurance will not cover services provided by Brooke McNeal, N.D.**

#### Phone Consultations:

- We do bill for phone consultations. For convenience we consult with many clients by phone. Phone consults require the same time and expertise by Brooke McNeal, N.D. as office visits and will be billed accordingly. Long distance clients are required to have a valid credit card on file at all times.
- Long distance clients may elect to receive invoices after each visit, in which case payment is expected within 30 days of receipt of invoice.

#### Wellness Packages:

- All wellness packages include a comprehensive new client homeopathic consultation, individualized wellness plan, and all homeopathic remedies (including shipping).
- Follow up credits must be used within one year from date of purchase. Unused consultations within the year may be transferred to family members or friends who are already established clients. Transferred credits will be good for one year from date of transfer.
- Wellness package must be paid for in full at time of elected package.
- Brooke McNeal, ND will alert you when your package is about to expire, or when all your follow up credits have been used. At that time, you may elect to purchase a new follow up package, or begin a la carte follow ups.

By signing this payment agreement, you are indicating that you understand and agree to the terms of service explained above. You are also indicating that you have given your permission to Brooke McNeal, N.D. to charge your credit card for services rendered or if any of the fees explained above apply to you.

Name of Patient or Legal Guardian: \_\_\_\_\_

Type of Card: Visa MC Card Number: \_\_\_\_\_

Expiration: \_\_\_\_\_ Security Code: \_\_\_\_\_ Billing Zip Code: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

#### Please indicate your preferred method of payment for a la carte follow ups:

bill credit card after each visit

mail invoices so I may send payment and charge any unpaid invoices greater than 30 days old to the above credit card

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Name:

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### Confidentiality Statement

Your privacy is important to us. All records and interactions between Brooke McNeal, N.D. and the client are entirely confidential.

Outlined below is a brief summary of your rights and protections under the Health Insurance Portability and Accountability Act (HIPAA). You can learn more about your rights from the website at <http://www.hhs.gov/ocr/hipaa/> or by calling 1-866-627-7748.

You have the right to:

- Ask to see and get a hard copy or e-copy of your health records, if readily producible.
- Have corrections added to your health information.
- Receive a notice that tells you how your health information may be used or shared.
- Decide if you want to give your permission before your health information can be used or shared for certain purposes, such as marketing.
- Request where you would like to be contacted.
- Ask that your information not be shared. For example, you could ask your doctor not to share your medical record with other doctors in the office.
- Receive breach notifications in a timely manner should any breach of protected health information occur.
- Request restriction of information to a health plan when you pay out of pocket, in full for health care services.

We will:

- **Not** sell your protected health information for marketing, and other purposes requiring authorization.
- Obtain authorization prior to disclosing protected health information for any use or disclosure that is not for treatment, payment, or health care operations, or otherwise permitted or required by the Privacy Rule.

Including:

- Psychotherapy notes
- Research and Marketing
- Disclosure of immunization information (can be oral consent)
- For disclosure to a third party: attorney, medical representative or a stand alone electronic patient health record, or family member who is not participating in or paying for treatment.

If you believe your rights are being denied or your health information isn't being protected, you can:

- File a complaint with your provider.
- File a complaint with the U.S. Government.

If it is necessary to reduce or prevent a serious threat to your health and safety, or the health and safety of another individual or the public, your doctor has the obligation to disclose any relevant information.

Name of Client or Legal Guardian: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



Name:

Date:

**Electronic Communications:**

Brooke McNeal, N.D. takes every precaution to protect your information and communication with us. Unfortunately, text messaging and email are not 100% secure. We are unable to communicate with you via email or text without signed consent. Please initial next to the forms of communication you consent to, and sign at the bottom to authorize communication. If you do not wish to use text messaging or email, no signature is required.

\_\_\_ I understand that text messaging is not a secure method of communication, and I am authorizing communication by this method.

\_\_\_ I understand that email is not a secure method of communication, and I am authorizing communication by this method.

Name of Patient or Legal Guardian: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\*In order to reduce our carbon foot-print and expedite the flow of service, our preferred method of delivery for invoices and receipts is via Intuit Quickbooks Online. This information is delivered to you via email over Intuits secure servers that use industry best practices to protect your information. The only information contained in these communications will be your name, address, and service (i.e. new client intake – brief). However, you have a right to request that your billing communications not be delivered in this manner.

**Case Study Release**

Occasionally, Brooke McNeal, N.D. likes to share client stories via blog post, articles, presentations, etc. to illustrate the amazing power of homeopathy. We would be very grateful if you would allow us to share your case story for these purposes. All identifying information will be removed for your protection.

I, \_\_\_\_\_ hereby give Brooke McNeal, N.D. permission to use my (or my dependent's) case for the following purposes (please mark all that you are giving permission for):

- \_\_\_ Research cases
- \_\_\_ Grant proposal writing/presentations; funding purposes
- \_\_\_ General Media (ie. articles in professional and layperson magazines, television/radio interviews, etc)
- \_\_\_ Professional Presentations
- \_\_\_ I would like to be informed any time my story is used

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

Name:

Date:

HOMEOPATHIC GENERALS FORM

Please circle the answers to the corresponding statements as honestly and accurately as possible. Some of these questions may not seem directly related to your health concerns, however they will help us find the best homeopathic remedy for you. Feel free to add explanations to your answers if you so choose.

WEATHER

Cold weather affects me negatively

Strongly disagree      Slightly disagree      Neutral      Slightly agree      Strongly agree

Rainy or humid weather affects me negatively

Strongly disagree      Slightly disagree      Neutral      Slightly agree      Strongly agree

Hot weather affects me negatively

Strongly disagree      Slightly disagree      Neutral      Slightly agree      Strongly agree

Change of weather affects me negatively

Strongly disagree      Slightly disagree      Neutral      Slightly agree      Strongly agree

Wind or thunderstorms affect me negatively

Strongly disagree      Slightly disagree      Neutral      Slightly agree      Strongly agree

I can tolerate exposure to warm sun (around 85 degrees) for a duration of  
10 min. or less      10-30 min.      30-60 min.      1-2 hours      2-4 hours      4 hours or more

I generally feel better in the following atmosphere/weather

Mountains      Seashore      Dry weather      Rainy/Stormy weather      Sunny weather      Cloudy weather

My symptoms get worse during the following seasons:

No season affects my symptoms      Spring      Summer      Fall      Winter

If so, which symptoms worsen? \_\_\_\_\_

ENVIRONMENT

Bright light affects me negatively

Strongly disagree      Slightly disagree      Neutral      Slightly agree      Strongly agree

Warm rooms affect me negatively

Strongly disagree      Slightly disagree      Neutral      Slightly agree      Strongly agree

Cold open air affects me negatively

Strongly disagree      Slightly disagree      Neutral      Slightly agree      Strongly agree

Loud noise affects me negatively

Strongly disagree      Slightly disagree      Neutral      Slightly agree      Strongly agree

Cold drafts affect me negatively (fans, A/C, wind)

Strongly disagree      Slightly disagree      Neutral      Slightly agree      Strongly agree

Strong odors affect me negatively

Strongly disagree      Slightly disagree      Neutral      Slightly agree      Strongly agree

TIME OF DAY

The time of day that I generally feel the best or the most energetic is \_\_\_\_\_ AM/PM until \_\_\_\_\_ AM/PM

The time of day that I generally feel the worst or have the lowest energy is \_\_\_\_\_ AM/PM until \_\_\_\_\_ AM/PM

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GENERAL PHYSICAL CHARACTERISTICS

I tend to become uncomfortable faster in a room that is  
Warmer than usual (80 degrees) Cooler than usual (60 degrees) (Circle the one that tends to bother you more)

Tight clothing affects me negatively (If so, around what part of the body? \_\_\_\_\_)  
Strongly disagree Slightly disagree Neutral Slightly agree Strongly agree

During sleep, I experience the following  
Restlessness Sleep walking Teeth grinding Uncovering Perspiration Heat Coldness Snoring  
Strange dreams Talking in sleep Frequent urination Frequent waking (at a specific hour? \_\_\_\_\_)

My usual sleep position is  
On back On abdomen On side (right or left?) Feet/arms uncovered Fully covered Head also covered

In general, I tend to perspire  
Never Only with exertion When heated When cold When nervous Easily, all the time

The part of my body where I tend to perspire the most is \_\_\_\_\_

FOOD & DRINKS

I crave the following flavors strongly on a daily basis (you may circle more than one)  
Sweet Salty Sour Spicy Bitter Smoked Pungent

I crave the following types of food or drinks strongly on regular basis (you may circle more than one)  
Apples Bacon Beer Bread Butter Cake/Cookies Cheese Chocolate Coffee Eggs Fish Fresh  
fruit Fried food Frozen food Garlic Ham Ice Ice cream Indigestible things (clay, chalk, etc.)  
Lemons/Lemonade Liquor Meat Milk Nuts/Nut butters OnionsOlives Oranges Pastries Pickles  
Potatoes Salsa Sausage Shellfish Tea Vegetables Wine Other: \_\_\_\_\_

If all food were healthy, I would enjoy the following foods/drinks multiple times per day:  
\_\_\_\_\_

I tend to dislike the following foods, drinks, or flavors:  
\_\_\_\_\_

With regard to thirst, on an average temperature day without physical exertion, I feel the need to drink water  
or another beverage to quench my thirst  
Almost never Several times per day Several times per hour Every few minutes

I prefer my water  
Hot Room temperature Cold Ice cold

I prefer my food  
Hot Cold No strong preference

Name:

Date:

FEARS

I have a strong fear of:

Darkness	Becoming seriously ill	Knives or needles
Thunderstorms	Loved one becoming ill or injured	Blood
Heights or falling	Ghosts	Spiders or insects
Small or narrow places	Evil	Snakes
Strangers	Failure	Animals (what kind? _____)
Robbers/intruders	Poverty	Being alone
Water, lakes, or the ocean	Death	Being in public or in a crowd
Contagious disease/germs	Insanity	That something terrible will happen

Other fears or phobias: \_\_\_\_\_

MENTAL & EMOTIONAL CHARACTERISTICS

In general, I tend to feel restless

Almost never	Less than once a week	Once a week	Once a day	More than once a day
--------------	-----------------------	-------------	------------	----------------------

If so, is there a part of your body that tends to be the most restless \_\_\_\_\_?

In general, I feel the need to keep things clean or organized

Almost never	Less than once a week	Once a week	Once a day	More than once a day
--------------	-----------------------	-------------	------------	----------------------

In general, I tend to feel impatient or hurried

Almost never	Less than once a week	Once a week	Once a day	More than once a day
--------------	-----------------------	-------------	------------	----------------------

In general, I tend to feel suspicious

Almost never	Less than once a week	Once a week	Once a day	More than once a day
--------------	-----------------------	-------------	------------	----------------------

In general, I tend to feel jealous or envious

Almost never	Less than once a week	Once a week	Once a day	More than once a day
--------------	-----------------------	-------------	------------	----------------------

In general, I tend to feel irritable or angry (whether you express it or not)

Almost never	Less than once a week	Once a week	Once a day	More than once a day
--------------	-----------------------	-------------	------------	----------------------

In general, I tend to criticize myself

Almost never	Less than once a week	Once a week	Once a day	More than once a day
--------------	-----------------------	-------------	------------	----------------------

In general, I tend to criticize others (either verbally or in my thoughts)

Almost never	Less than once a week	Once a week	Once a day	More than once a day
--------------	-----------------------	-------------	------------	----------------------

I think about disagreeable or troubling events from the past

Almost never	Less than once a week	Once a week	Once a day	More than once a day
--------------	-----------------------	-------------	------------	----------------------

I have urges to throw things, hit people/things, or break things (whether you act on this desire or not)

Never/Almost never	Less than once a week	Once a week	Once a day	More than once a day
--------------------	-----------------------	-------------	------------	----------------------

Name:

Date:

I have urges to hurt myself (whether you act on this urge or not)

Never/Almost never      Less than once a week      Once a week      Once a day      More than once a day

I cry easily or often

Strongly disagree      Slightly disagree      Neutral      Slightly agree      Strongly agree

If someone upsets or offends me, I feel nervous confronting that person about it

Strongly disagree      Slightly disagree      Neutral      Slightly agree      Strongly agree      Only with authority figures

I am offended easily by rudeness or injustice

Strongly disagree      Slightly disagree      Neutral      Slightly agree      Strongly agree

I am overly sensitive to hearing sad or cruel stories about children, adults, or animals

Strongly disagree      Slightly disagree      Neutral      Slightly agree      Strongly agree

Being scolded, reprimanded, or criticized affects me negatively

Strongly disagree      Slightly disagree      Neutral      Slightly agree      Strongly agree

I am frightened or startled easily

Strongly disagree      Slightly disagree      Neutral      Slightly agree      Strongly agree

I often worry about social status and success

Strongly disagree      Slightly disagree      Neutral      Slightly agree      Strongly agree

I often feel impulsive, or have sudden changes in mood or behavior

Strongly disagree      Slightly disagree      Neutral      Slightly agree      Strongly agree

I have difficulty making decisions

Strongly disagree      Slightly disagree      Neutral      Slightly agree      Strongly agree

I have a strong desire to travel or to be outdoors in nature

Strongly disagree      Slightly disagree      Neutral      Slightly agree      Strongly agree

I have a strong affinity for and love of animals

Strongly disagree      Slightly disagree      Neutral      Slightly agree      Strongly agree

I have a strong religious or spiritual faith

Strongly disagree      Slightly disagree      Neutral      Slightly agree      Strongly agree

I am often forgetful of the following

Dates      Names      Numbers      Words      Places      Faces      Recent events      Distant past events

What I was about to say      What someone just told me      What I was about to do      What I just did      What I just said

I have had dreams or daydreams that have come true (clairvoyant or prophetic dreams)

Less than twice      Less than 4 times      Less than 10 times      More than 10 times

Name:

Date:

Regarding any past emotionally traumatic events, I feel

Grief Guilt Anger Fear Sadness Shame Indifference Peace Empowerment

Other: \_\_\_\_\_

Regarding my health condition, and the possibility of recovery, I feel

Very optimistic Hopeful Somewhat doubtful Discouraged Fearful Severe despair

In general, my overall outlook on life at this time is

Very optimistic Generally positive Indifferent Pessimistic

Loathing life Desire death Suicidal thoughts Suicidal plans

When I am feeling sad or upset, at the very worst point, I need

To be completely alone To have someone nearby To be distracted from my feelings

To vent about what I am feeling To have someone talk to me about what I'm feeling, and console me

If I am feeling at my worst, the following makes me feel much better (circle any that apply)

Rest/Sleep Massage/Pressure Crying Yelling Music Dancing  
Company Being alone Talking Quiet Darkness  
Sunshine Eating Gentle exercise  
Vigorous exercise Exposure to heat  
Exposure to cold

Anything else that consistently makes you feel better:

\_\_\_\_\_

Anything that consistently makes you feel worse:

\_\_\_\_\_

(If you have a partner/spouse) My general feeling toward my partner/spouse is

Loving Affectionate Indifferent Dissatisfied Disappointed Irritated Resentment  
Disgust Hatred

The frequency of my sexual desire or interest is (whether you act on this desire or not)

Never/Less than 1x/year 1-6 x/year Every 1-2 months Every 1-2 weeks 2-4x/week  
Once/day More than once/day

(If sexually active) Approximate frequency of intercourse

Never/Less than 1x/year 1-6 x/year Every 1-2 months Every 1-2 weeks 2-4x/week  
Once/day More than once/day

Approximate frequency of masturbation

Never/Less than 1x/year 1-6 x/year Every 1-2 months Every 1-2 weeks 2-4x/week  
Once/day More than once/day

I experience the following (circle any that apply):

Lack of sexual enjoyment Difficulty reaching orgasm  
Troubling sexual thoughts Impotence