This file is comprised of the forms that you can print out and complete prior to your initial diagnostic evaluation here at the Center for Cognitive Therapy. It is very important that you fill them out in their entirety and bring them with you when you come in for your evaluation. If you have any questions, please feel free to contact Dr. Cory F. Newman at 215-898-3466. We look forward to being of assistance to you.

OUR LOCATION

The Center for Cognitive Therapy is located at 3535 Market Street, which is on the northeast corner of 36th and Market Street. Please use the elevator after signing in with Security in the lobby and go to the Penn Behavioral Health Suite on the Mezzanine Level, where you will check in. After checking in on the Mezzanine, please proceed two floors up to the 2nd floor where you will wait in the Penn Behavioral Health waiting area for the clinician who will be conducting your intake evaluation. (Our clinical offices are located on the 2nd floor).

Thank you,

The therapists and staff of the Center for Cognitive Therapy
I would like to tell you a few important points about the Center for Cognitive Therapy and its policies.

The Center for Cognitive Therapy is a treatment and training center. Your initial appointment at the Center is a 2-2.5 hour diagnostic evaluation that typically takes place with an advanced-degree-candidate assessment trainee as well as his/her supervisor (most often, Dr. Mary Anne Layden, The Director of Training and Education). Please keep in mind that the purpose of this evaluation is not to provide therapy; rather, it is to obtain a comprehensive picture of your problems, provide a preliminary diagnosis, and ascertain what treatment program can be of benefit to you. If our evaluation indicates that cognitive therapy (also known as cognitive-behavioral therapy, or “CBT”) will be an appropriate treatment for you, we will then assign a therapist to begin meeting with you for sessions. However, if the results of our evaluation suggest that outpatient cognitive therapy may not be the treatment of choice for you at this time, we will then refer you to a more appropriate treatment setting, and we will move forward the results of our evaluation (with your signed permission).

Research has indicated that a full course of treatment yields the most positive results. Cognitive therapy is designed to be a time-effective treatment (usually 12 to 20 sessions); however, depending on the nature and severity of your problems, the desirable length of treatment may be longer than this. It is important to keep in mind that dropping out of therapy before a full course has been completed has been shown to reduce the benefits of cognitive therapy.

If in the future you need to cancel a therapy session, please notify your therapist prior to the session, so you can reschedule a session promptly. The Center’s policy is to require a minimum of 24 hours notice for cancellation (in regards to the evaluation as well as therapy session). If you call us on the day of the appointment to cancel or simply fail to arrive, we will have to charge a standard missed session fee of $81. Please make every effort to speak to your therapist regarding any appointment cancellation before the 24 hour deadline. [Note: If you arrive late for a schedule session, your therapist may still be available to see you, but only for the remainder of the time that has been allocated for your visit. However, you will be billed for the entire time for which the appointment was scheduled.]

Enclosed in this packet you will find several forms. Please complete these at home and bring them with you on the day of your evaluation. This will facilitate the evaluation process. At the time of your evaluation, please feel free to ask any questions you may have regarding cognitive therapy in general or the Center for Cognitive Therapy in particular. Thank you in advance for your cooperation.

Sincerely,

Cory F. Newman, Ph.D., ABPP
Director
CENTER POLICIES ON PATIENT FEES

The Center for Cognitive Therapy is a non-profit organization that is part of the Department of Psychiatry in the University of Pennsylvania Health Care System. The purpose of this statement is to explain our fee structure and suggest ways to make payments more easily.

We require patients to pay their fee or co-pay each time they have a session. Please plan to arrive ten minutes before each session in order to check in with the administrative assistant, pay your bill for that session (via cash, personal check, Visa, Mastercard, or Discover), and receive a receipt, as well as complete the appropriate session forms (such as the Beck mood inventories).

If you plan to seek out-of-network reimbursement from your insurance company, the receipt which you will be given contains all the information and codes needed by your insurance company. You should attach this to any insurance form which your company may require you to submit.

Mental health benefits vary greatly with each insurance company (whether in-network or out-of-network). We suggest that you contact your insurance company to determine your benefits. Things to be determined are: deductibles, percentage of the charge you will be reimbursed, number of visits allowed per year, and if services need to be precertified. Most insurance companies limit the number of mental health visits you may have each year. It is your responsibility to know your benefits and to keep track of sessions used. We will be happy to let you know at any time how many visits you have had with us, but we cannot determine when you have exceeded your limit since the total may include visits you may have had with providers not in our Center.

If your personal information or insurance coverage changes at any point during your treatment here, it is your responsibility to inform our staff immediately of the change. Failure to do so may result in loss covered benefits here and increases in your financial responsibility.

If you must miss an appointment, please give us at least 24 hours notice. The clinician's time is valuable and, if we have 24 hours notice, we can reschedule other clinical activities for him or her and we will not have to charge you for the missed session. For a missed psychotherapy session the late cancellation/no show fee is $81.00. Insurance benefits typically do not cover phone sessions or no-show fees.

In all instances, please do not hesitate to ask your therapist if you have any questions about your policy.

I have read and I understand all of the information contained above.

______________________________  ______________________________
Patient's name (printed)        Date signed

______________________________  ______________________________
Signature of Patient            Date signed

______________________________  ______________________________
Signature of Staff Member       Date signed
INFORMED CONSENT TO TREATMENT AT THE CENTER FOR COGNITIVE THERAPY

Welcome to the Center for Cognitive Therapy at the University of Pennsylvania. This document contains important information about our services and policies. It will be a permanent part of your patient record. By signing it, you give your consent to treatment. If you have any questions about this form or other documents, please ask.

Any type of therapy has benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you many experience uncomfortable feelings. On the other hand, therapy often leads to better relationships, solutions to problems, and reductions in distress. The course of therapy differs for each individual. Cognitive therapy calls for active effort on your part, including your participation in the therapy sessions themselves, as well as the therapy homework assignments you will be asked to do.

To obtain treatment at the Center for Cognitive Therapy, you will undergo an initial diagnostic evaluation, and you will meet with a licensed clinician or by a trainee supervised by a licensed clinician. If we believe our services would be helpful for you in meeting your objectives, you will be offered therapy with a psychologist or a licensed clinical social worker. If you need low-cost treatment, you may request to be treated by an advanced trainee who is supervised by a licensed clinician. You will have the right to contact the supervisor in charge of your care. You will not be able to use any insurance benefits. Typically, therapy sessions are once a week for 50 minutes (plus the time to complete your mood questionnaires upon arrival). The number of sessions varies according to the type of problems you have. You have the right to ask questions regarding your treatment, and your therapist will attempt to answer them to your satisfaction. If you withdraw from treatment, you have the right to a referral to another practitioner.

Most insurance companies require you to authorize your therapist to provide a clinical diagnosis. You can call your insurance company to find out how this information is stored or used. Your insurance company may limit the number of sessions it will cover.

All papers and documents concerning your treatment will be kept confidential. No information concerning your treatment will be released without your written consent, except as required by law or in a situation deemed potentially life threatening. By state law, licensed providers are mandated to report information that professional judgment determines constitutes a threat of serious harm to self or others, or indicates child abuse or neglect. Under these specific circumstances, information about you can be released without your written approval. However, your therapist will make every effort to keep you actively informed about such developments.

---

Patient’s name (printed)

Signature of patient or legal guardian     Date signed

Signature of witness (CCT staff member)     Date signed
A PATIENT'S BILL OF RIGHTS

1. A patient has the right to receive treatment at the Center for Cognitive Therapy in an atmosphere of dignity and to be shown respect by all personnel.

2. A patient has the right to know and be involved in the formulation of individualized treatment plans, and the goals to be obtained through this treatment.

3. A patient has the right to know what risks, if any, are involved in treatment, and whether or not the treatment will include any new or experimental techniques (or medications if the patient is concurrently being seen by a psychiatrist or psychiatric Resident in the University of Pennsylvania Health System).

4. A patient has the right to refuse treatment.

5. A patient has the right to request an alternative treatment plan or type of therapy being provided.

6. A patient has the right to know that information and records regarding his or her treatment will be obtained and stored with the utmost confidentiality accordance with the rules and regulations governing same.

7. A patient has the right to know the cost of treatment as well as any amount that may be billed through a third a party.

8. A patient has the right to make grievances known via the following procedure: first, through the patient's therapist; second, through the Director of the Center for Cognitive Therapy (Cory F. Newman, Ph.D., 215-898-3466).

9. A patient has the right to receive emergency service through the Emergency Room of the University of Pennsylvania Medical Center.

10. A patient has the right to have any questions regarding treatment or policy to be answered promptly and appropriately by his or her therapist, and/ or by the Director.

<table>
<thead>
<tr>
<th>Patient signature</th>
<th>Date signed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Witness signature</th>
<th>Date signed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
PERSONAL DATA

First Name: ____________________________  Middle Name: ______________________
Last Name: ____________________________  Date: _____________________________
Gender:  ○ Male  ○ Female  Birth Date: ____________________________
State/Country of Birth: ____________________________  Age: _______________________
Ethnicity (optional):  ○ Native American  ○ Asian  ○ Black  ○ Hispanic  ○ White  ○ Other

Home Address:
Street: ____________________________
City: ____________________________
State: ____________________________
Zip Code: ____________________________

Phone Number:
Home: ____________________________
Work: ____________________________
Cell: ____________________________

May we call you at?:
Home  ○ Yes  ○ No
Work  ○ Yes  ○ No
Cell  ○ Yes  ○ No

May we leave a message for you?:  ○ Yes  ○ No
May we leave a detailed message for you?:  ○ Yes  ○ No

Employment Status:
Full-time employed  ○
Part-time employed  ○
Unemployed seeking work  ○
Unemployed/other  ○
Full-time homemaker  ○
Retired  ○
Disabled  ○
Full-time student  ○

Occupation:
Self: ____________________________
Place of Employment: ____________________________

Spouse/Partner: ____________________________
Place of Employment: ____________________________

Emergency Contact Person:

Home Address of Emergency Contact
Street

Phone Number

City, State and Zip
PERSONAL DATA
(Side 2)

Second Person to Contact: ___________________________

Home Address of Second Person to Contact:

_________________________________________________

Street

_________________________________________________

City, State and Zip

Phone Number ___________________________

Education:

○ (1) 6th Grade
○ (2) 7th to 11th Grade
○ (3) High School Diploma
○ (4) Some College
○ (5) College Degree
○ (6) Advanced Graduate or Professional School

Number of Children or Dependents: ______

Full Name:

Age: _____ Living with you? ○ Yes ○ No

Full Name:

Age: _____ Living with you? ○ Yes ○ No

Full Name:

Age: _____ Living with you? ○ Yes ○ No

Others?

Your Marital Status:

○ Married
○ Living as Married
○ Widowed
○ Divorced
○ Separated
○ Never Married
1. Who is your primary care physician or the physician who sees you most often (please include doctor's office phone number)?

2. When was the last time you had a physical checkup?

3. Have you been treated by a physician or hospitalized in the last year?  
   If yes please specify: ____________________________________________
   ○ Yes  ○ No

4. Has there been any change in your general health in the past year?  
   If yes please specify: ____________________________________________
   ○ Yes  ○ No

5. Are you taking any non-psychiatric medication or over the counter drugs at the present time?  
   If yes please list:
   ________________________________________________________________
<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
<th>Frequency</th>
<th>Name of Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6. Have you ever been told you had a thyroid problem?  
   ○ Yes  ○ No

7. Have you ever been told you had diabetes or hypoglycemia?  
   ○ Yes  ○ No

8. Do you get short of breath during mild exertion or when you lie down?  
   ○ Yes  ○ No

9. Do you have a history of: (fill in circle for all that apply)
   ○ Stroke       ○ Anemia       ○ Rheumatic Fever  ○ Asthma or COPD
   ○ High or Low Blood Pressure  ○ Heart Pain (angina)  ○ Heart Murmur  ○ Heart Attack
   ○ Heart Surgery  ○ Tuberculosis  ○ Ulcers  ○ Cancer
   ○ Difficult pregnancy, labor, or delivery  ○ Premature termination of pregnancy (miscarriage or abortion)

10. Are you pregnant or think you may be pregnant?  
    ○ Yes  ○ No  Not applicable ______

11. Have you ever had fits, seizures, convulsions, or epilepsy?  
    ○ Yes  ○ No

12. Do you have a prosthetic heart valve?  
    ○ Yes  ○ No

13. Do you have any other current medical conditions?  
    If yes please specify: ________________________________
    ○ Yes  ○ No

14. Do you have any medication or food allergies?  
    If yes please specify: ________________________________
    ○ Yes  ○ No
Have you ever been hospitalized for any emotional or psychiatric reason?  ○ Yes  ○ No
If yes, how many times have you been hospitalized?
<table>
<thead>
<tr>
<th>Dates</th>
<th>Name of Hospital</th>
<th>Reason for Hospitalizations</th>
<th>Was it helpful?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Have you ever received psychiatric or psychological treatment before?  ○ Yes  ○ No
If yes, please complete:
<table>
<thead>
<tr>
<th>Dates</th>
<th>Name of Clinician</th>
<th>Reason for Treatment</th>
<th>Was it helpful?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Are you taking any medication for psychiatric reasons?  ○ Yes  ○ No
If yes, please complete:
<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
<th>Frequency</th>
<th>Name of prescriber</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Have you ever made a suicide attempt?  ○ Yes  ○ No
If yes, how many times have you attempted suicide?
<table>
<thead>
<tr>
<th>Approximate date</th>
<th>What did you do to hurt yourself?</th>
<th>Were you hospitalized?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Others:
Have you ever experienced emotional or verbal abuse as a child?  

_Yes _No _Unsure

Have you ever experienced sexual abuse as a child?  

_Yes _No _Unsure

Have you ever experienced non-sexual physical abuse as a child?  

_Yes _No _Unsure

Have you ever experienced being raped (including acquaintance rape and marital rape)?  

_Yes _No _Unsure

Have you ever experienced emotional or verbal abuse as an adult?  

_Yes _No _Unsure

Have you ever experienced non-sexual physical abuse as an adult?  

_Yes _No _Unsure

Have you ever been concerned about your sexual behavior in terms of unusual practices, addiction, high-risk, identity confusion, or other matters?  

_Yes _No _Unsure

Has anyone in your family ever made a suicide attempt?  

_Yes _No _Unsure

If so, how is this person related to you? ________________________________

Has anyone in your family died from suicide?  

_Yes _No _Unsure

If so, how is this person related to you? ________________________________

Does anyone in your family have a history of mental illness, alcohol abuse, drug abuse, or other addictions?  

_Yes _No _Unsure

If so, how are these persons related to you, and what is a summary of their problems?
ALCOHOL AND DRUG USE HISTORY

1. When did you last drink?  
2. Has alcohol ever caused problems for you?  
3. Has anyone ever told you that alcohol has caused a problem for you or complained about your drinking?  
4. Has your use of alcohol ever caused a relationship problem with anyone?  
5. Has your use of alcohol ever caused any problem at work or performing other responsibilities?  
6. Has your use of alcohol ever caused any legal problems such as being arrested or being stopped for DUI?  
7. Have you ever gotten "hooked" on a prescribed medication or taken a lot more of it than you were supposed to?  
   If yes, please list those medications:  
8. Have you ever been hospitalized because of a drug or alcohol problem?  
   If yes, when and where were you hospitalized?  
9. Have you ever been to a detoxification program?  
   If yes, when and where did you receive such treatment?  
10. Have you ever been to a drug or alcohol rehabilitation program?  
    If yes, when and where did you receive such treatment?  
11. Have you ever attended a 12 step meeting such as AA, NA, Al-Anon, Al-Ateen, ACOA?  
12. Have you ever used any street drugs such as cocaine, marijuana, speed, LSD?  
    If yes, please list all street drugs below:  
13. Has anyone ever told you that drugs have caused a problem for you or complained about your drug use?  
14. Has your use of drugs ever caused a relationship problem with anyone?  
15. Has your use of drugs ever caused any problem at work or performing other responsibilities?  
16. Have drugs ever caused any physical problems such as headaches, shakiness, stomach aches, seizures, or liver damage?  
17. What is the longest period you have been drug free? (If applicable)  
18. When was the last time you used any drugs?  
19. Has your use of drugs ever cause any psychological problems such as feeling depressed?  
20. Has your use of drugs ever caused any legal problems such as being arrested or being stopped for DUI?
**Instructions**

These questions are about the kind of person you generally are; that is, how you have usually felt or behaved over the past several years. Circle “YES” if the question completely or mostly applies to you or “NO” if the question does not apply to you. If you do not understand a question, leave it blank.

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td><strong>Have you avoided jobs or tasks that involved having to deal with a lot of people?</strong></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td><strong>Do you avoid making friends with people unless you are certain they will like you?</strong></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td><strong>Do you find it hard to be “open” even with people you are close to?</strong></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td><strong>Do you often worry about being criticized or rejected in social situations?</strong></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td><strong>Are you usually quiet when you meet new people?</strong></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td><strong>Do you believe that you’re not as good, as smart, or as attractive as most other people?</strong></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td><strong>Are you afraid to do things that might be challenging or to try anything new?</strong></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td><strong>Is it hard for you to make everyday decisions, like what to wear or what to order in a restaurant, without advice and reassurance from others?</strong></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td><strong>Do you depend on other people to handle important areas of your life, such as finances, child care, or living arrangements?</strong></td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td><strong>Do you have trouble disagreeing with people even when you think they are wrong?</strong></td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td><strong>Do you find it hard to start projects or do things on your own?</strong></td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td><strong>Is it so important to you to be taken care of by others that you are willing to do unpleasant or unreasonable things for them?</strong></td>
<td></td>
</tr>
<tr>
<td>13.</td>
<td><strong>Do you usually feel uncomfortable when you are by yourself?</strong></td>
<td></td>
</tr>
<tr>
<td>Question</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>----</td>
<td>-----</td>
</tr>
<tr>
<td>14. When a close relationship ends, do you feel you immediately have to find someone else to take care of you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Do you worry a lot about being left alone to take care of yourself?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Are you the kind of person who spends a lot of time focusing on details, order, or organization, or making lists and schedules?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. Do you have trouble finishing things because you spend so much time trying to get them exactly right?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. Are you very devoted to your work or to being productive?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19. Do you have very high standards about what is right and what is wrong?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20. Do you have trouble throwing things out because they might come in handy someday?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21. Is it hard for you to work with other people or ask others to do things if they don't agree to do things exactly the way you want?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22. Is it hard for you to spend money on yourself and other people?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23. Once you've made plans, is it hard for you to make changes?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>24. Have other people said that you are stubborn?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25. Do you often get the feeling that people are using you, hurting you, or lying to you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>26. Are you a very private person who rarely confides in other people?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>27. Do you find that it is best not to let other people know much about you because they will use it against you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>28. Do you often feel that people are threatening or insulting you by the things they say or do?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>29. Are you the kind of person who holds grudges or takes a long time to forgive people who have insulted or slighted you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Question</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>----</td>
<td>-----</td>
</tr>
<tr>
<td>Are there a lot of people you can’t forgive because they did or said something to you a long time ago?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you often get angry or lash out when someone criticizes or insults you in some way?</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>Have you sometimes suspected that your spouse or partner has been unfaithful?</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>When you are out in public and see people talking, do you often feel that they are talking about you?</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>When you are around people, do you often get the feeling that you are being watched or stared at?</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>Do you often get the feeling that the words to a song or something in a movie or on TV has a special meaning for you in particular?</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>Are you a superstitious person?</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>Have you ever felt that you could make things happen just by making a wish or thinking about them?</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>Have you had personal experiences with the supernatural?</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>Do you believe that you have a “sixth sense” that allows you to know and predict things?</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>Do you often have the feeling that everything is unreal, that you are detached from your body or mind, or that you are an outside observer of your own thoughts or movements?</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>Do you often see things that other people don’t see?</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>Do you often hear a voice softly speaking your name?</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>Have you had the sense that some person or force is around you, even though you cannot see anyone?</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>Are there very few people who you’re really close to outside of your immediate family?</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>Question</td>
<td>Answer Options</td>
<td></td>
</tr>
<tr>
<td>---------------------------------------------------------------------------------------------</td>
<td>----------------</td>
<td></td>
</tr>
<tr>
<td>45. Do you often feel nervous when you are around people you don't know very well?</td>
<td>NO YES</td>
<td></td>
</tr>
<tr>
<td>46. Is it NOT important to you to have friends or romantic relationships or to be involved with your family?</td>
<td>NO YES</td>
<td></td>
</tr>
<tr>
<td>47. Would you almost always rather do things alone than with other people?</td>
<td>NO YES</td>
<td></td>
</tr>
<tr>
<td>48. Do you have little or no interest in having sexual experiences with another person?</td>
<td>NO YES</td>
<td></td>
</tr>
<tr>
<td>49. Are there really very few things that give you pleasure?</td>
<td>NO YES</td>
<td></td>
</tr>
<tr>
<td>50. Does it not matter to you what people think of you?</td>
<td>NO YES</td>
<td></td>
</tr>
<tr>
<td>51. Do you rarely have strong feelings, like being very angry or feeling joyful?</td>
<td>NO YES</td>
<td></td>
</tr>
<tr>
<td>52. Do you like being the center of attention?</td>
<td>NO YES</td>
<td></td>
</tr>
<tr>
<td>53. Do you tend to flirt a lot?</td>
<td>NO YES</td>
<td></td>
</tr>
<tr>
<td>54. Do you often find yourself &quot;coming on&quot; to people?</td>
<td>NO YES</td>
<td></td>
</tr>
<tr>
<td>55. Do you like to draw attention to yourself by the way you dress or look?</td>
<td>NO YES</td>
<td></td>
</tr>
<tr>
<td>56. Do you tend to be very dramatic in your actions and speech?</td>
<td>NO YES</td>
<td></td>
</tr>
<tr>
<td>57. Are you more emotional than most other people, for example, sobbing when you hear a sad story?</td>
<td>NO YES</td>
<td></td>
</tr>
<tr>
<td>58. Do you often change your mind about things depending on the people you're with or what you have just read or seen on TV?</td>
<td>NO YES</td>
<td></td>
</tr>
<tr>
<td>59. Do you feel that you are good friends even with people who provide a service, like your plumber, your car mechanic, and your doctor?</td>
<td>NO YES</td>
<td></td>
</tr>
<tr>
<td>60. Are you more important, more talented, or more successful than most other people?</td>
<td>NO YES</td>
<td></td>
</tr>
</tbody>
</table>
61. Have people told you that you have too high an opinion of yourself?  NO  YES  PQ64
62. Do you think a lot about the power, success, or recognition that you expect to be yours someday?  NO  YES  PQ65
63. Do you think a lot about the perfect romance that will be yours someday?  NO  YES  PQ66
64. When you have a problem, do you almost always insist on seeing the top person?  NO  YES  PQ67
65. Do you try to spend time with people who are important or influential?  NO  YES  PQ68
66. Is it important to you that people pay attention to you or admire you in some way?  NO  YES  PQ69
67. Do you feel that you are the kind of person who deserves special treatment, or that other people should automatically do what you want?  NO  YES  PQ70
68. Do you often have to put your needs above other people’s?  NO  YES  PQ71
69. Have others complained that you take advantage of people?  NO  YES  PQ72
70. Do you generally feel that other people’s needs or feelings are really not your problem?  NO  YES  PQ73
71. Do you often find other people’s problems to be boring?  NO  YES  PQ74
72. Have people complained to you that you don’t listen to them or care about their feelings?  NO  YES  PQ75
73. When you see someone who is successful, do you feel that you deserve it more than they do?  NO  YES  PQ76
74. Do you feel that others are often envious of you?  NO  YES  PQ77
75. Do you find that there are very few people who are worth your time and attention?  NO  YES  PQ78
76. Have other people complained that you act too “high and mighty” or arrogant?  
77. Have you become frantic when you thought that someone you really cared about was going to leave you?  
78. Do relationships with people you really care about have lots of extreme ups and downs?  
79. Does your sense of who you are often change dramatically?  
80. Are you different with different people or in different situations, so that you sometimes don’t know who you really are?  
81. Have there been lots of sudden changes in your goals, career plans, religious beliefs, and so on?  
82. Have there been lots of sudden changes in the kinds of friends you have or in your sexual identity?  
83. Have you often done things impulsively?  
84. Have you tried to hurt or kill yourself or threatened to do so?  
85. Have you ever cut, burned, or scratched yourself on purpose?  
86. Does your mood often change in a single day, based on what’s going on in your life?  
87. Do you often feel empty inside?  
88. Do you often have temper outbursts or get so angry that you lose control?  
89. Do you hit people or throw things when you get angry?  
90. Do even little things get you very angry?  
91. When you get very upset, do you get suspicious of other people or feel disconnected from your body or that things are unreal?
The following questions apply to things you did before you were 15 years old.

<table>
<thead>
<tr>
<th>Question</th>
<th>NO</th>
<th>YES</th>
</tr>
</thead>
<tbody>
<tr>
<td>92. Before you were 15, did you bully, threaten, or scare other kids?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>93. Before you were 15, did you start fights?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>94. Before you were 15, did you hurt or threaten someone with a weapon, like a bat, brick, broken bottle, a knife, or a gun?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>95. Before you were 15, did you do cruel things to someone that caused him or her physical pain or suffering?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>96. Before you were 15, did you hurt animals on purpose?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>97. Before you were 15, did you mug, rob, or forcibly take something from someone by threatening him or her?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>98. Before you were 15, did you force someone to do something sexual?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>99. Before you were 15, did you set fires?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>100. Before you were 15, did you deliberately destroy things that weren't yours?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>101. Before you were 15, did you break into houses, other buildings, or cars?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>102. Before you were 15, did you lie a lot or con other people to get something you wanted or to get out of doing something?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>103. Before you were 15, did you sometimes shoplift, steal something, or forge someone’s signature for money?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>104. Before you were 15, did you run away and stay away overnight?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The following two questions apply to things you did before you were 13 years old.

<table>
<thead>
<tr>
<th>Question</th>
<th>NO</th>
<th>YES</th>
</tr>
</thead>
<tbody>
<tr>
<td>105. Before you were 13, did you often stay out very late, long after the time you were supposed to be home?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>106. Before you were 13, did you often skip school?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
CURRENT LIFE SITUATION

Name: ___________________________ Date: ________________________

I. Current Problems and Daily Routine
   A. What are the main problems that are causing you to seek treatment at this time:

   B. Circle a number indicating the severity of your problems.

   1 Mildly Upsetting  2 Moderately Upsetting  3 Severe  4 Extremely Severe  5 Incapacitating

   C. When did your problems begin?

   D. Please briefly describe what you do on a typical weekday, starting with the time you wake up in the morning and ending with the time you go to sleep at night.

   1. Did this pattern change when your present difficulties began? Yes____ No____

   2. If yes, in what way?

   B. Please briefly describe what you do on your weekends or days off.

   1. Did this pattern change when your present difficulties began? Yes____ No____

   2. If yes, in what way?
CURRENT LIFE SITUATION

II. Current Social Life

A. Describe how you are getting along with people other than your family or those you live with (e.g., friends, acquaintances, neighbors, co-workers) and how people generally seem to feel about you. If you are having problems relating to other people, please describe those problems.

B. Have your relationships with friends, acquaintances, neighbors, or co-workers changed as a result of your current difficulties? Yes________ No________

1. If yes, briefly describe the ways in which they have changed.

C. How difficult is it for you to make friends these days? (circle number)

1 2 3 4 5 6 7 8 9 10
Very Difficult Somewhat Difficult About Average Somewhat Easy Very Easy

D. How difficult is it for you to keep friends these days? (circle number)

1 2 3 4 5 6 7 8 9 10
Very Difficult Somewhat Difficult About Average Somewhat Easy Very Easy

E. About how many close friends do you have (people you can confide in)?_____

1. How often do you talk to them?
2. How often do you see them?

F. Rate the degree to which you generally feel relaxed and comfortable in social situations. (circle a number)

1 2 3 4 5 6 7 8 9 10
Very Tense and Uncomfortable Somewhat Tense and Uncomfortable Neutral Somewhat Relaxed and Comfortable Very Relaxed and Comfortable
CURRENT LIFE SITUATION

III. Current Work (and/or School) Life

A. Briefly describe your attitude and behavior at work or school. Describe any problems you are having carrying out your responsibilities or dealing with problems.

1. Did your attitude or behavior change when your present difficulties began?
   Yes_______ No_______

2. If yes, in what way?

B. What do you like about your current line of work, or schooling?

C. What do you dislike about your current line of work, or schooling?

IV. Intimate Relationships

A. How comfortable are you now with the idea of being trusting, open, and close (vulnerable) in a love relationship? (Please answer even if you are not currently in such a relationship – circle a number)

   1 2 3 4 5 6 7 8 9 10
   Bx  tremely Moderately  Neutral  Mo  derately  Ex  tremely
   Uncomfortable  Uncomfortable  Fairly Self- Co  mfortable  Co  mfortable
   With Closeness;  With Closeness;  Protective but  W  ith Closeness;  With Closeness;
   Very Self-  Pretty Self-  Willing to be  Pretty Willing to be  Very Willing to
   Protective  Protective  Vulnerable at Times  Vulnerable  be  Vulnerable

B. IF NOT MARRIED OR COHABITATING: Are you currently dating anyone? Yes  No

1. If yes, are you experiencing significant difficulties in this/these dating relationship(s)?
   Yes_______ No_______

2. If yes, please describe.
CURRENT LIFE SITUATION

3. If you are not currently dating anyone, how satisfied are you with this situation?

- Completely Dissatisfied
- Mostly Dissatisfied
- Somewhat Dissatisfied
- Neutral
- Evenly Mixed (Conflicted) Feelings
- Somewhat Satisfied
- Mostly Satisfied
- Completely Satisfied

C. IF MARRIED OR COHABITATING: Rate your overall level of satisfaction with the marital/committed relationship. (circle a number)

<table>
<thead>
<tr>
<th>Very Dissatisfied</th>
<th>Moderately Dissatisfied</th>
<th>Neutral</th>
<th>Moderately Satisfied</th>
<th>Very Satisfied</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

1. Indicate which, if any, are the positive aspects of the relationship for you.

2. Indicate which, if any, are the negative aspects of the relationship for you.

D. On a scale from one to ten, indicate how critical you think your spouse/partner is of you? (circle a number)

<table>
<thead>
<tr>
<th>Not at All Critical</th>
<th>Mildly Critical</th>
<th>Moderately Critical</th>
<th>Pretty Critical</th>
<th>Very Critical</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

E. On a scale from one to ten, indicate how satisfied you are with the quality of your sexual relations with your partner. (circle a number)

<table>
<thead>
<tr>
<th>Very Dissatisfied</th>
<th>Moderately Dissatisfied</th>
<th>Neutral</th>
<th>Very Satisfied</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

F. List any sexual problems that might be related to your reason for seeking treatment.
CURRENT LIFE SITUATION

G. IF COHABITATING: Do you plan to formalize your commitment?
   Yes ___  No ___  Unsure ___

   If "No" or "Unsure" what are the obstacles to a long-term formal commitment?

V. Children and Family Relationships

   A. List below each child with whom you have a parental relationship whether as a biological parent, stepparent, or other relationship.

<table>
<thead>
<tr>
<th>Name of Child</th>
<th>Age</th>
<th>Relationship (e.g., daughter, son, stepdaughter, stepson, etc.)</th>
<th>If the child does not live with you full-time, explain living arrangements.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

   B. Do any of your children present special problems to you and/or your spouse/partner?
   Yes _______  No _______

   If yes, please describe:

   C. How would you describe your present relationship with your family of origin?

   D. Indicate which, if any, of these relationships is currently a significant source of support or distress for you. If a relationship is problematic, describe briefly what the problem(s) seems to be.
LIFE HISTORY INVENTORY

NAME: _______________________________ DATE: ______________

I. Family of Origin

   A. Father: Name: ___________________ Age: ________________

       Occupation: ___________________ Health: ________________

       If deceased, give age at time of death: _____ How old were you at the time? _____

       Cause of death: ___________________ 

   B. Mother: Name: ___________________ Age: ________________

       Occupation: ___________________ Health: ________________

       If deceased, give age at time of death: _____ How old were you at the time? _____

       Cause of death: ___________________ 

   C. Siblings: Age(s) of brother(s): ___________ Age(s) of sister(s): ___________

       Where were you in birth order? ______________

       Any significant details about siblings: ___________________________________________

       __________________________________________

D. Disruptions in childhood upbringing:

   1. Did you experience any significant moves as a child? Yes_____ No_____

       a. If yes, how old were you? ______________

       b. Did you have significant emotional or behavioral difficulties associated with the
          move(s)? Yes_____ No_____

       If yes, describe your difficulties:
25

LIFE HISTORY INVENTORY

2. Were you ever separated from one or both parents for a significant period of time during your childhood? Yes ______ No ______
   a. If yes, how old were you? ______
   b. Did you have any significant emotional or behavioral difficulties associated with the separation? Yes ______ No ______
      If yes, what were the difficulties and what were the circumstances and reason for the separation?

3. If you were not raised by your parents, who raised you and between what years of age?
   B. How would you characterize your father (or father substitute) when you were a child?

1. What was his attitude toward you as a child?

2. How much were you able to confide in your father as a child?

3. How did your father discipline you when you misbehaved?
LIFE HISTORY INVENTORY

F. How would you characterize your mother (or mother substitute) when you were a child?

1. What was her attitude toward you as a child?

2. How much were you able to confide in your mother as a child?

3. How did your mother discipline you when you misbehaved?

G. Describe the atmosphere in the home in which you grew up.

1. How did your parents get along?

2. How did the children get along?

3. What were some of the important spoken or unspoken family rules?
4. How openly were affection and anger expressed?

5. How were problems handled?

6. What were your parents' attitudes about sex? How much was sex discussed in the home?

7. How involved were your parents in the social interests of the children? How comfortable did you feel having your friends over to the house?

H. If you have a stepparent, how old were you when your biological parent(s) remarried? _____

I. Was religion an important part of your upbringing? Yes_____ No_______
   If yes, in what way was it important?

J. Did you have any particular fears as a child? Yes_______ No_______
   1. If yes, what were they?

   2. Which of these, if any, do you still have?
LIFE HISTORY INVENTORY

II. School/Occupational History

A. How did you feel about school as you grew up?

1. Elementary:

2. High School:

3. College:

4. Post-graduate education:

B. How were your grades?

1. Elementary:

2. High school:

3. College:

4. Post-graduate education:

C. Growing up, were you ever in trouble with the police or school authorities? Yes_______ No_______

1. If yes, how old were you at the time?_________

2. Describe specific incident(s):

D. Did you graduate from:

1. High school? Yes_______ No_______ Year_________

2. A vocational training program? Yes_______ No_______ Year_________

3. College? Yes_______ No_______ Year_________

4. Graduate/professional school? Yes_______ No_______ Year_________

5. Did you take any time off from school during your education? Yes_______ No_______

If yes, why?
B. Describe the types of jobs you have held and the reasons for leaving past jobs.

<table>
<thead>
<tr>
<th>DATES</th>
<th>JOB DESCRIPTION</th>
<th>EMPLOYER</th>
<th>REASON FOR ENDING</th>
</tr>
</thead>
</table>

F. Have you made a career change? Yes____ No____

1. If yes, describe what led to your career change(s).

III. Social History: Friendships

A. As a child (younger than age 13), how difficult was it for you to make friends? (circle a number)

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very Difficult</td>
<td>Somewhat Difficult</td>
<td>About Average</td>
<td>Somewhat Easy</td>
<td>Very Easy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
LIFE HISTORY INVENTORY

B. As a child, how difficult was it for you to keep friends? (circle a number)

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Very Difficult</td>
<td>Somewhat Difficult</td>
<td>About Average</td>
<td>Somewhat Easy</td>
<td>Very Easy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

C. About how many close friends did you have as a child?______

D. As an adolescent, how difficult was it for you to make friends? (circle a number)

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Very Difficult</td>
<td>Somewhat Difficult</td>
<td>About Average</td>
<td>Somewhat Easy</td>
<td>Very Easy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

E. As an adolescent, how difficult was it for you to keep friends? (circle a number)

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Very Difficult</td>
<td>Somewhat Difficult</td>
<td>About Average</td>
<td>Somewhat Easy</td>
<td>Very Easy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

F. About how many close friends did you have as an adolescent?______

IV. Social History: Intimate Relationships

A. At what age did you start dating?______

B. List the serious relationships from your past (if any) that you think have had the most impact on you. Do not include ongoing committed relationships.

<table>
<thead>
<tr>
<th>First Name</th>
<th>His/Her age now</th>
<th>Year you became a couple</th>
<th>Year you moved in together (if applicable)</th>
<th>Year you married (if applicable)</th>
<th>Year you separated or broke up</th>
<th>Year you divorced (if applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
LIFE HISTORY INVENTORY

C. Is there any common pattern that seems to take place in many of your romantic involvements?

D. IF MARRIED OR COHABITATING:

1. What year did you meet your spouse/partner?

2. What did you like about him/her?

3. How long did you know each other before getting married/living together?

E. How much would you describe yourself as attracted to the opposite sex?

<p>| | | | | | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>Definitely Not</td>
<td>Mostly Not</td>
<td>Somewhat or Unsure</td>
<td>Mostly Yes</td>
<td>Definitely Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

F. How much would you describe yourself as attracted to the same sex?

<p>| | | | | | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>Definitely Not</td>
<td>Mostly Not</td>
<td>Somewhat or Unsure</td>
<td>Mostly Yes</td>
<td>Definitely Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>