JAMES D. EYERMAN, M.D., DLFAPA
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*Thank you for taking the time to complete this Self Report! It will save us **lots** of time.*

Please keep one copy of this completed form and **send it back to me with USPS, or as an attachment using the Signal Messaging App**. Please note that HIPAA regulations prohibit sending it by email.
Voice Mail and Signal App are preferred modes of contact. YOUR INITIALS_____

New Patient Self-Report

Name:_____ SSN _____ Birthdate (MM/DD/YYYY):____/____/_____
Email:_____ Cell: _____ I use text messaging: yes / no
Work phone:_____ Home phone_____
The best ways to reach me are:_____
Address:_____City_____State_____ZIP _____
Place of Birth (city and country):_____ Time of Birth:_____
Occupation: _____ Employer:_____
For how long have you worked at the present job? _____
My emergency contact_____ Emergency contact phone:_____
Information may be released to my emergency contact. INITIALS_____
Marital Status: Married / Divorced / Widowed / Single / Other (specify): _____
Who referred you?_____ Phone of referring person:_____
I authorize release of information to my referring professional. INITIALS_____
Primary Care Physician:_____ Phone:_____
I authorize release of information to my primary care physician: INITIALS_____
Psychotherapist:_____ Phone:_____
I authorize release of information to my psychotherapist: _____Phone:_____INITIALS_____

Therapy Agreement

I agree to holistic, integrative therapy with James D. Eyerman, M.D., and will follow all mutually agreed upon recommendations [medication(s), herbal supplement, dream recording, diet, support group, exercise, spa treatment, self-care, etc.]. I will consult with Dr. Eyerman before making any changes in treatment. I agree to abstain from self-injurious behavior, suicidal behavior, and intoxication with recreational substances (drugs, and alcohol).
I shall request my pharmacy to telephone Dr. Eyerman for medication refills at least one week beforehand.
I agree to pay my consultation fee [$300 per 30 minutes] at each session. I understand that Dr. Eyerman takes medication related phone calls without charge. Phone calls for urgent therapy: I will pay a special emergency after-hours fee of $25 per minute.

Cancellation Policy: I will notify Dr. Eyerman at least 72 hours before cancelling an appointment. I will pay for otherwise missed appointments.

Termination policy: If I should break this agreement, then I release Dr. Eyerman from my care and will seek therapy with another doctor within the next 30 days.

Signed_____ Date: _____

Please briefly describe why you are seeking help:

How long have you had these problems? _____

Have you sought therapy before? Yes/No

If Yes:

Who treated you? _____ Where? _____ When? _____

Please describe the therapy:

Current medications

Please fill out the information below on **all prescription medications** you are **currently** taking:

Prescription Medication Name	Prescribing Doctor	Dosage (e.g., 100mg)	Dosing Schedule (e.g., 2x a day)	Benefits	Adverse reactions

Please fill out the information below on **all over-the-counter medications** (e.g., aspirin, etc.) you are taking:

Over-the- counter Medicine Name	Why do you take this medicine?	When do you take this medicine?

Please fill out the information below on **all vitamins, minerals, herbs, food supplement/diet plans** you are taking:

Name of vitamin/mineral/herb/food supplement/diet plan	Why do you take this?	How do you take this?

Please list **all adverse reactions** you have had to any drug, food, or substance:

Please fill out the information below on **all prescription medications** you have taken **previously**:

Medication Name	Dosage (e.g., 100mg)	Dosing Schedule (e.g., 2x a day)	How long did you take this medication? (e.g., 9 months)	Benefits	Adverse reactions

Which treatment or combination of treatment(s) were **helpful**?

Have you ever been to a psychiatric hospital? Yes/No

If Yes: When? _____ Where? _____
Under what circumstances?

Send **requests to previous doctors and hospitals** for:
1) Psychiatric and medical evaluations and treatments
2) Laboratory reports
3) Discharge summaries

To be sent to JAMES EYERMAN, MD, 1996 Union Street, #307, San Francisco CA 94123, FAX: 844-309-1317 as soon as possible. Date completed: _____

Have you been treated for any other medical or psychological problems in the past 5 years? Please list them below:

Are there any stressful circumstances that may be contributing to your current problems? If so, describe briefly below:

Is there a family history of stressful circumstances or significant life events? If so, how many generations back?

Habits, past and present

A. Do [Did] you smoke? Yes/No *If Yes:* How much a day?_____
Did you quit? Yes/No. When?_____

B. Do [Did] you drink alcohol? Yes/No *If Yes:* How much? _____

C. Did you experiment with alcohol or drugs before the age of 13? Yes/No

D. Has alcohol ever been identified as a problem by you, your family, or your friends? Yes/No
If so, explain:

E. If you have had problem thinking, have you ever had: (Check all that apply)

[] blackouts [] fights [] dui [] seizures [] delirium tremens [] legal problems
[] relationship problems [] benders

Do [Did] you use street drugs?
If so: When? _____
Which drugs and at which frequency?

G. Do [did] you drink caffeinated beverages (coffee, tea, cola)? *If Yes*: Number of cups per day_____

H. Have you ever abused:
[] prescription drugs [] anti-anxiety drugs [] diet pills [] sleeping pills
[] over-the-counter medications [] laxatives
[] any other medications (list them):_____
[] I have never abused any drugs or medications

I. Do you have any allergies? Yes/No

J. Allergies to medication? Yes/No *If Yes:* list the medications you are allergic to:

Family history

List all **relatives** with **emotional or substance abuse** problems. Note their relationship to you.

[ ] Anxiety disorders (chronic worry) *Relative* _____

[ ] Depression (Chronic Sadness) *Relative* _____

[ ] Seizure Disorder (Fits) *Relative* _____

[ ] Alcohol Abuse *Relative* _____

[ ] Drug Abuse (Street/Prescription) *Relative* _____

[ ] Bipolar disorder (Manic Depressive Illness, Mood Swings) *Relative* _____

[ ] Mental Retardation. *Relative* _____

[ ] Schizophrenia. *Relative* _____

[ ] Panic Attacks *Relative* _____

[ ] Fear of Leaving the House. *Relative* _____

[ ] Violence *Relative* _____

[ ] Suicide or Attempts *Relative* _____

[ ] Other Problems?

[ ] *If* someone was successfully treated, what treatment seemed to work?

Family members' medical history: (Check all that apply)

[ ] chronic pain; headache, facial, back, limbs, abdominal, pelvic, etc

[ ] visual problems [ ] hearing problems [ ] fainting [ ] seizures [ ] lung problems [ ] heart problems

[ ] blood pressure problems (high/low) [ ] digestive problems. [ ] liver disease [ ] weight problems

[ ] glandular; thyroid, pituitary, adrenal, etc. [ ] arthritis [ ] diabetes [ ] low blood sugar [ ] cancer

[ ] neuromuscular diseases [ ] bleeding problems [ ] Alzheimer's disease [ ] movement disorders

[ ] any other diseases (please list below)

Social History

A. Where did you grow up? _____

B. While growing up, did you live with your:

[ ] mother [ ] father

[ ] mother and father [ ] family member

[ ] foster home [ ] other_____

C. Do you have brothers and sisters? [ ] yes

Names and ages:

Significant relationships with your siblings?

D. When you grew up, did you

[ ] live essentially in the same area [ ] move 1 to 3 times as a child [ ] move many times?

E. To the best of your knowledge, were you the result of a normal, full-term pregnancy and birth? Yes/No

If No, please explain briefly

F. Did you have any unusual childhood illnesses? Yes/No

If Yes, please explain

G. Did you have any developmental problems, such as?

[ ] difficulty with walking/talking [ ] bed wetting

[ ] a slow learner at school [ ] sleep walking

[ ] other_____ [ ] school fears

H. In childhood, were you abused? Yes/No

If Yes:

Who was the perpetrator? _____

Were you abused (Check all that apply):

[ ] physically [ ] sexually [ ] emotionally

I. How far did you go in school?

[ ] I did not finish high school
[ ] high school grad
[ ] some college
[ ] bachelor's degree
[ ]some grad school
[ ] graduate degree

J. Your performance in school?

[ ] failed regularly
[ ] failed occasionally
[ ] passed
[ ] above average
[ ] excelled

K. Your current work level:

[ ] unemployed
[ ] unskilled labor
[ ] skilled labor
[ ] clerical
[ ] management
[ ] sales
[ ] self-employed
[ ] professional

L. Job history: [ ] constant [ ] sporadic

M. Job satisfaction: [ ] not happy [ ] just ok [ ] satisfied

N. Length of employment on most recent job:

[ ] 1 to 3 years [ ] 4 to 6 years [ ] more than 7 years

O. What is your religion or spiritual practice? _____

P. List your children with names and ages. Note your relationship with them and list 3 of their strengths and weaknesses

Q. Problem areas in your life?

[ ] marital [ ] work [ ] financial
[ ] family [ ] health [ ] substance abuse
[ ] legal [ ] sexual [ ] emotional

Other Comments:

Sexual history

What is your gender? Male Female Non-binary Other: _____

What are your gender pronouns? He/Him She/Her They/Them Other: _____

What is your biological sex? Male Female

Biological Females:

I. At what age you're your period start? __ Were you properly prepared to know what to expect? Yes/ no
II. Are your periods regular? Yes/No
III. Do you have pain with your periods? Yes/No
IV. Do you have mood changes with your periods? Yes / No
V. How many timeshave you been pregnant? ___
vi. How many children do you have? _____

VI. Ever had a miscarriage? Yes/No Abortion? Yes/No
VII. Post menopause? Yes/No how long? _____
VIII. Postpartum depression? Yes/No
VII. Sexual functioning:
IX. Problems with sexual interest? Yes/No
X. Problems with orgasm? Yes/No
XI. Problems with pain during intercourse? Yes/No
XII. Are there any sexual difficulties you wish to discuss with your therapist? Yes/no
If Yes, when did they begin? _____

****

Biological Males:

I. Difficulty with erections? Yes no
II. Problems with sexual interest? Yes no
III. Are there other sexual difficulties you wish to discuss with the therapist? Yes no
Comments?

Past medical history

Have you ever had or ever been treated for any of the following?

[ ] asthma
[ ] bronchitis
[ ] chronic cough
[ ] coughing up blood
[ ] frequent chest colds
[ ] pneumonia
[ ] tonsillitis
[ ] sinus trouble
[ ] mastoiditis
[ ] deafness
[ ] defective hearing
[ ] frequent sore throat
[ ] running ear
[ ] shortness of breath
[] heart trouble
[] low blood pressure
[ ] high blood pressure
[ ] diseases of the blood
[ ] kidney or bladder trouble
[ ] albumin in urine
[ ] bladder trouble
[ ] prostate gland disease
[ ] venereal disease
[] impotence
[ ] head injury
[ ] frequent headaches
[ ] shock treatment
[ ] temper tantrums.
[ ] fainting spells
[ ] epilepsy
[ ] convulsions/fits/seizures
[ ] dizziness
[ ] blackout spells
[ ] multiple sclerosis
[ ] paralysis
[ ] vomiting
[ ] fainting
[ ] neck trouble
[ ] back injury
[ ] worn a brace
[ ] back pain
[ ] broken bones
[ ] injured cartilage

[ ] tuberculosis
[ ] lung trouble
[ ] abnormal chest x-ray findings
[ ] pleurisy
[ ] shortness of breath
[ ] nose allergy
[ ] chronic hoarseness
[ ] frequent head colds
[ ] frequent nosebleeds
[ ] defective vision
(requiring glasses)
[ ] defective hearing
(requiring hearing aids)
[ ] unusual tendency to bleed
when injured
[ ] rapid/irregular heartbeat
[ ] pain in chest
[ ] arteriosclerosis
[ ] bedwetting
[ ] urinary problems (painful, excessive, too little, involuntary)
[ ] swollen ankles
[] frigidity
[ ] penile discharge or sore
[ ] meningitis
[ ] nausea
[ ] coma
[ ] muscle weakness (paralysis)
[ ] abnormal movements
[ ] poor coordination
[ ] hiccups
[ ] sleeping difficulties
[ ] tremors
[ ] tics
[ ] trouble speaking
[ ] numb or tingling limbs
[ ] blurred or double vision
[ ]rheumatism
[ ]arthritis
[ ] swelling in joints
[ ] stiffness
[ ] cramps
[ ] weakness

[ ] skin infection
[ ] skin disorders
[ ) itching
[ ] fatigue
[ ] gastrointestinal upset
[ ] dysentery (diarrhea) abdomen (belly)
[ ] nervous stomach
[ ] ulcers
[ ] intestinal trouble
[ ] vomiting spells
[ ] goiter
[ ] thyroid gland trouble
[ ] gland trouble
[ ) liver disease
[ ] low blood sugar
[ ] high blood sugar
[ ] diabetes (sugar in urine)
[ ] unusual weight gain or loss
[ ] intestinal worms
[ ] tularemia
[ ] whooping cough
[ ] typhoid fever
[ ] measles
[ ] adhesions from operation
[ ] chronic unexplained pain.
[ ] stab/gunshot wound
[ ] jittery
[ ] weakness
[ ] chills

[ ] excessive sweating
[ ] loss of appetite
[ ] frequent hunger
[ ] intestinal obstruction
[ ] longstanding pain in
[ ] colitis {colon trouble)
[ ] hemorrhoids (piles)
[ ] nausea
[ ] constipation
[ ] dark/bloody stools
[ ] amoebiasis
[ ] malaria
[ ] rheumatic fever
[ ] unexplained fever
[ ] jaundice
[ ] scarlet fever
[ ] hepatitis
[ ] diphtheria
[ ] mononucleosis
[ ] mumps
[ ] chicken pox
[ ] polio
[ ] brucellosis
[ ] excessive thirst[ ] unusual weight gain or loss[ ] anemia
[ ] tumor
[ ] hernia
[ ] cysts
[ ] swelling

Hospitalization Dates, Reasons, Treatments, Outcomes, Complications:

Additional comments?

Current physical symptoms

Below is a list of problems and complaints that people sometimes have. Please read each one carefully. After you have done so, please ***circle*** one of the four numbers to the right thatbest decribes how much that problem has bothered or distressed you during the past month. Mark only one number for each problem and do not skip any items.

1 = not at all 2 = a little 3 = quite a bit 4 = extremely

		1	2	3	4				
1	Headache					14	Indigestion/nausea	1	2 3 4
2	Dizziness	1	2	3	4	15	Stomach boating	1	2 3 4
3	Ringing in ears	1	2	3	4	16	Passing more gas	1	2 3 4
4	Trouble hearing	1	2	3	4	17	Food intolerance	1	2 3 4
5	Lumps in throat	1	2	3	4	18	Constipation/diarrhea	1	2 3 4
6	Trouble smelling/ tasting	1	2	3	4	19	Pain with urination	1	2 3 4
7	Pains in neck	1	2	3	4	20	Pain with intercourse	1	2 3 4
8	Back pain	1	2	3	4	21	Muscle pain/soreness	1	2 3 4
9	Chest discomfort	1	2	3	4	22	Joint pain/stiffness	1	2 3 4
10	Rapid heart	1	2	3	4	23	Body numbness or tingling	1	2 3 4
11	Shortness of breath	1	2	3	4	24	Trembling	1	2 3 4
12	Frequent urination	1	2	3	4	25	Hot/cold spells	1	2 3 4
13	Stomach pain	1	2	3	4	26	Weakness in your body	1	2 3 4

Any additional comments**?**

Psychological self-rating scale

Instructions: below is a list of problems and complaints that people sometimes have. Please read each one carefully. After you have done so, please **circle** one of the four numbers to the right that best describes how much that problem has bothered or distressed you during the past month. Mark only one number for each problem and do not skip any items.

1 = not at all 2 = a little 3 = quite a bit 4 = extremely

27	Low energy	1 2 3 4	40	Restless/disturbed sleep	1 2 3 4
28	Irregular periods (females)	1 2 3 4	41	Poor appetite	1 2 3 4
29	Painful periods (females)	1 2 3 4	42	Early am awakening	1 2 3 4
30	Impotence (males)	1 2 3 4	43	Feeling future hopeless	1 2 3 4
31	Crying easily	1 2 3 4	44	Trouble concentrating	1 2 3 4
32	Feeling blue/sad	1 2 3 4	45	Irritable/annoyed	1 2 3 4
33	Feeling lonely	1 2 3 4	46	Tense/keyed up	1 2 3 4
34	Nervousness/ shakiness inside	1 2 3 4	47	Thoughts of death	1 2 3 4
35	Worrying frequently	1 2 3 4	48	Restlessness	1 2 3 4
36	Lack of interest	1 2 3 4	49	Unable to relax	1 2 3 4
37	Feeling fearful	1 2 3 4	50	Feeling worthless	1 2 3 4
38	Feelings easily hurt	1 2 3 4	51	Feeling guilty	1 2 3 4
39	Trouble/falling asleep	1 2 3 4	52	Ideas you deserve Punishment	1 2 3 4
53	Urges to hurt others	1 2 3 4	66	Fear closed spaces	1 2 3 4
54	Urges to hurt yourself	1 2 3 4	67	Fear bridges/heights	1 2 3 4
55	Thoughts that	1 2 3 4	68	Uneasy in crowds	1 2 3 4
56	Seeing things that aren't there	1 2 3 4	69	Feeling people talk About you	1 2 3 4
57	Seeing things others can't	1 2 3 4	70	Feel there's a Plot against you	1 2 3 4
58	Hearing voices or sounds	1 2 3 4	71	Fear of losing control	1 2 3 4
59	Hearing special messages from tv/radio	1 2 3 4	72	Plans of ending Your life	1 2 3 4
60	Thoughts put into your mind	1 2 3 4	73	Feel like more than One person	1 2 3 4
61	Frequently rechecking what you do	1 2 3 4	74	Excessive alcohol Drug abuse	1 2 3 4
62	Thoughts you can't get out of your mind	1 2 3 4	75	Excessive eating	1 2 3 4
63	Familiar things seem strange or unusual	1 2 3 4	76	Excessive sexual Feelings/activity	1 2 3 4
64	Suddenly scared	1 2 3 4	77	Fear of eating	1 2 3 4
65	Fear of leaving home	1 2 3 4	78	Other excessive behavior	1 2 3 4

Psychological self-rating scale

Instructions:
Below is a list of problems and complaints that people sometimes have. Please read each one carefully. After you have done so, please **circle** one of the four numbers to the right that best decribes how much that problem has bothered or distressed you during the past month. Mark only one number for each problem and do not skip any items.

1 = not at all 2 = a little 3 = quite a bit 4 = extremely

79	Thoughts racing	1	2	3	4		
80	Impulsive spending	1	2	3	4		
81	Increased activity at night	1	2	3	4		
82	Decreased need for sleep	1	2	3	4		
83	Feel you have special powers others don't	1	2	3	4		
84	Health is a concern	1	2	3	4		
85	Decreased sexual interest	1	2	3	4		
86	Easily distracted	1	2	3	4		
87	Memory problems	1	2	3	4		
88	Recent weight change	1	2	3	4		
89	Flashbacks of past trauma	1	2	34			
90	Easily startled	1	2	3	4		
91	Nightmares	1	2	3	4		
92	I found myself somewhere and didn't know how I got there	1	2	3	4		
93	I lost time (gaps in memory)	1	2	3	4		
94	Out of body experiences	1	2	3	4		
95	Life limited by fear	1	2	3	4		
96	Wish you were the opposite sex	1	2	3	4		
97	Concerns about sexuality	1	2	3	4		
98	Making movements or Sounds you can't control	1	2	3	4		
99	Problems associated w/work	1	2	3	4		
100	Family problems associated with alcohol/drugs	1	2	3	4		
101	Health problems associated with alcohol/drugs	1	2	3	4		
102	Legal problems as associated with alcohol/drugs	1	2	3	4		
103	Recent trauma or loss (past, present or anticipated)	1	2	3	4		
104	Rapidly shifting mood	1	2	3	4		
105	Trouble maintaining relationships	1	2	3	4		
106	Feeling unjustly criticized	1	2	3	4		
107	Not able to make important decisions	1	2	3	4		
108	External reality seemed altered	1	2	3	4		
109	My body seemed altered or felt unusual	1	2	3	4		

Beck depression inventory B: please rate the following areas in your life:

1) Pessimism
0 I do not feel sad.
1 I feel sad much of the time.
2 I am sad all the time.
3 I am so unhappy that I can't stand it

2) Pessimism
0 I am not discouraged about my future.
1 I feel more discouraged about my future than i used to be.
2 I do not expect things to work out for me.
3 I feel my future is hopeless and will only get worse.

3) Past failure
0 I do not feel like a failure.
1 I have failed more than I should have.
2 As I look back, I see a lot of failures.
3 I feel I am a total failure as a person.

4) Loss of pleasure
0 I get as much pleasure as I ever did from the things i enjoy.
1 I don't enjoy things as much as I used to.
2 I get very little pleasure from the things I used to enjoy.
3 I can't get any pleasure from the things I used to enjoy.

5) Guilty feelings
0 I don't feel particularly guilty.
1 I feel guilty over many things I have done or should have done.
2 I feel quite guilty most of the time.
3 I feel guilty all the time.

6) Punishment feelings
0 I don't feel i am being punished. 1 i feel i may be punished.
2 I expect to be punished.
3 I feel i am being punished.

7) Self-dislike
0 I feel the same about myself as ever.
1 I have lost confidence in myself.
2 I am disappointed in myself.
3 I dislike myself.

8) Self-criticalness
0 I don't criticize or blame myself more than usual.
1 I am more critical of myself than i used to be.
2 I criticize myself for all my faults.
3 I blame myself for everything bad that happens.

9) Suicidal thoughts or wishes.
0 I don't have any thoughts of killing myself.
1 I have thoughts of killing myself, but i would not carry them out.
2 I would like to kill myself.
3 I would kill myself if i had the chance.

10) Crying
0 I don't cry any more than i used to.
1 I cry more than i used to.
2 I cry over every little thing.
3 I feel like crying, but I can't.

11) Agitation
0 I am no more restless or wound up than usual.
1 I feel more restless or wound up than usual.
2 I am so restless or agitated that it's hard to stay still.
3 I am so restless or agitated that I must keep moving or doing something.

12) Interest
0 I have not lost interest in other people or activities.
1 I am less interested in other people or things than before.
2 I have lost most of my interest in other people or things.
3 It's hard to get interested in anything.

13) Indecisiveness
0 I make decisions about as well as ever.
1 I find it more difficult to make decisions than usual.
2 I have much greater difficulty in making decisions than i used to.
3 I have trouble making any decisions

14) Worthlessness
0 I do not feel I am worthless.
1 I don't consider myself as worthwhile and useful as i used to
2 I feel more worthless as compared to other people.
3 I feel utterly worthless.

15) Energy
0 I have as much energy as ever.
1 I have less energy than i used to have.
2 I don't have enough energy to do very much.
3 I don't have enough energy to do anything.

16) Changes in sleep
0 I have not experienced any change in my sleeping pattern.
1 a. I sleep somewhat more than usual / b. I sleep somewhat less than usual.
2 a. I sleep a lot more than usual / b. I sleep a lot less than usual.
3 a. I sleep most of the day / b. I wake up 1--2 hours early and can't get back to sleep.

17) Irritability
0 I am no more irritable than usual.
1 I am more irritable than usual.
2 I am much more irritable than usual.
3 I am irritable all the time.

18) Appetite
0 I have not experienced any change in my appetite.
1 a. My appetite is somewhat less than usual / b. My appetite is somewhat greater than usual.
2 a. My appetite is much less than before / b. My appetite is much greater than usual.
3 a. I have no appetite at all / b. I crave food all the time.

19) Concentration
0 I can concentrate as well as ever.
1 I can't concentrate as well as usual.
2 It's hard to keep my mind on anything for very long.
3 I find I can't concentrate on anything.

20) Tiredness
0 I am no more tired or fatigued than usual.
1 I get more tired or fatigued more easily than usual.
2 I am too tired or fatigued to do a lot of things I used to do.
3 I am too tired or fatigued to do most of the things I used to do.

21) Interest in sex
0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I am much less interested in sex now.
3 I have lost interest in sex completely.

Mood questionnaire

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Has there ever been a period when you were not your usual self and …	[ ] yes	[ ] no
You felt so good or so hyper that other people thought you were not your normal Self, or you were so hyper that you got into trouble?	[ ] yes	[ ] no
You were so irritable that you shouted at people or started fights or arguments?	[ ] yes	[ ] no
You felt much more self-confident than usual?	[ ] yes	[ ] no
You got much less sleep than usual and found you didn't really miss it?	[ ] yes	[ ] no
You were much more talkative and/or spoke much faster than usual?	[ ] yes	[ ] no
Thoughts raced through your head and/or you couldn't slow your mind down?	[ ] yes	[ ] no
You were so easily distracted by things around you that you had trouble Concentrating or staying on track?	[ ] yes	[ ] no
You had much more energy than usual?	[ ] yes	[ ] no
You were much more active and/or did many more things than usual?	[ ] yes	[ ] no
You were much more social or outgoing than usual—for example, You telephoned friends in the middle of the night?	[ ] yes	[ ] no
You were much more interested in sex than usual?	[ ] yes	[ ] no
You did things that were unusual for you that other people might have thought was excessive, foolish, or risky?	[ ] yes	[ ] no
You spent so much money that you or your family got into trouble?	[ ] yes	[ ] no
If you checked yes to more than one of the above, have you experienced several of these during the same period Of time?	[ ] yes	[ ] no

How much of a problem did any these situations cause you? (like being unable to work, having family, money or legal problems; and /or getting into serious arguments or fights)? *Please provide brief details below*:

Patient health questionnaire (PHQ-9)

Over the *last 2 weeks,* how often have you been bothered by any of the following problems?

(Circle # to indicate your answer: 0=Not at all, 1=several days, 2= More than half the days, 3=nearly everyday.)

1. Little interest or pleasure in doing things	0 1 2 3
2. Feeling down, depressed, or hopeless	0 1 2 3
3. Trouble falling or staying asleep, Or sleeping too much	0 1 2 3
4. Feeling tired or having little energy	0 1 2 3
5. Poor appetite or overeating	0 1 2 3
6. Feeling bad about yourself—or thatYou are a failure or have let yourself Or your family down	0 1 2 3 0 1 2 3
7. Trouble concentrating on things, such as reading the Newspaper or watching television	0 1 2 3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgetyor restless that you have been moving around a lot more than usual	0 1 2 3
9. Thoughts that you would be better off dead/ hurting yourself	0 1 2 3
10. How difficult have these problems made your work or home life?	0 1 2 3

PHQ-9 is adapted from *Prime MD Today*, developed by Drs Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues

HCL 32

At different times in their life everyone experiences changes or swings in energy, activity and mood ("highs and lows" or "ups and downs"). The aim of this questionnaire is to assess the characteristics of the "high" periods. Circle answers that apply to you.

1) How are you feeling today compared to your usual state?

Much worse than usual Worse than usual A little worse than usual

Neither better nor worse than usual A little better than usual Better than usual

Much better than usual

2) Compared to other people, my level of activity energy and mood: (*Not how you feel today, but how you are on average)*

is always rather stable and even is generally higher is generally lower

repeatedly shows periods of ups and downs

3) Please try to remember a period when you were in a "high" state (while not using drugs or alcohol). In such a state [circle the number]:

a. I need less sleep

b. I feel more energetic and more active

c. I am more self-confident

d. I enjoy my work more

e. I am more sociable (make more phone calls, go out more)

f. I want to travel and/or do travel more

g. I tend to drive faster or take more risks when driving

h. I spend more money/too much money

i. I take more risks in my daily life (in my work and/or other activities)

j. I am physically more active (sport etc.)

k. I plan more activities or projects.

l. I have more ideas, I am more creative

m. I am less shy or inhibited

n. I wear more colorful and more extravagant clothes/make-up

o. I want to meet or do meet more people

p. I am more interested in sex, and/or have increased sexual desire

q. I am more flirtatious and/or am more sexually active

r. I talk more

s. I think faster

t. I make more jokes or puns when I am talking

u. I am more easily distracted

v. I engage in lots of new things

w. My thoughts jump from topic to topic

x. I do things more quickly and/or more easily

y. I am more impatient and/or get irritable more easily

z. I can be exhausting or irritating for others

aa. I get into more quarrels

bb. My mood is higher, more optimistic

cc. I drink more coffee

dd. I smoke more cigarettes

ee. I drink more alcohol

ff. I take more drugs (sedatives, anti-anxiety pills, stimulants)

In the space below, please draw a **clock face** with the time arms at 3 0'clock:

Please record a recent **dream:**