# [FIRST POINT](https://www.firstpointurgentcare.org/" \t "_self) [URGENT CARE INC.](https://www.firstpointurgentcare.org/)

## ADULT-Immigration Screening Form

## First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Middle Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Preferred Name (Alias) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Place of Birth (City/Town/Village) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Country \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Address:

## Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Street Address Line 2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## City State / Province/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Alien Registration Number(A-number) if any: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Home Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Work Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Person completing this form:

## Self

## Other (complete information below)

## First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Middle Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Same contact information as patient (if not then complete info below)

## Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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## City State / Province/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Home Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Race: Asian Black White Prefer not to disclose Other

## Ethnicity: Not Hispanic/Latino Hispanic/Latino Prefer not to disclose Other

## Marital Status: Married Single

## Gender Identity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Primary insurance provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Claims Address Or EDI/Payor ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Policy ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Effective date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Who is the policy holder? Self Other Person

## If policy holder is separate person, please provide the information below:

## Name: First name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Date of birth of policy holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Patient relationship to policy holder (circle one): Self/Spouse/Child/Other

## I authorize First Point Urgent Care to correspond with me with email that is NOT encrypted and not HIPAA Compliant (circle one) True False

## Please initial below:

## \_\_\_\_\_\_\_\_ I have been given the opportunity to read the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

## \_\_\_\_\_\_\_\_\_ I have read, understand, and agree to the Payment Policy outlined by First Point Urgent Care (FPUC).

## Sharing of Medical Information.

## *\*\*\*Note: If the following information is left blank, we cannot share medical information with any person.*

## I authorize First Point Urgent Care to discuss my medical health information with:

## First Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Are you, or is there a chance you may be pregnant?\*

## \_\_\_I am pregnant

## \_\_\_I am not pregnant

## \_\_\_I am unsure if I am pregnant

## \_\_\_Not applicable

## Past Medical History (required):

## History of tuberculosis vaccine: Yes No

## History of latent tuberculosis: Yes No

## History of tuberculosis treatment: Yes No

## History of positive tuberculosis skin test: Yes No

## History of syphilis: Yes No

## History of gonorrhea: Yes No

## History of substance abuse: Yes No

## History of behavioral health medication: Yes No

## History of behavioral health admission: Yes No

## History of behavioral health counseling: Yes No

## History of Hansen's (skin) disease: Yes No

## History of Leprosy: Yes No

## If "yes" to any health history questions above, please provide date(s):

## \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Surgical History (Type of Surgery/Reason and Year):

## \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Medication Allergies (Name of Medication/Product and Reaction):

## \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Medications/Supplements (Name, Strength and Frequency):

## \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Other Providers you see (Name, Phone# and Specialty):

## \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Current Primary Care Physician (Name and Phone#):

## \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Today's Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Alcohol consumption screening AUDIT questionnaire:

## 1. How often do you have a drink containing alcohol?

## \_\_\_Never (0 points)

## \_\_\_Monthly or less (1 point)

## \_\_\_2 to 4 times a month (2 points)

## \_\_\_2 to 3 times a week (3 points)

## \_\_\_4 or more times a week (4 points)

## 2. How many drinks containing alcohol do you have on a typical day when you are drinking?

## \_\_\_1 or 2 (0 points)

## \_\_\_3 or 4 (1 point)

## \_\_\_5 or 6 (2 points)

## \_\_\_7 to 9 (3 points)

## \_\_\_10 or more (4 points)

## 3. How often do you have 5 or more drinks on one occasion?

## \_\_\_Never (0 points)

## \_\_\_Less than monthly (1 point)

## \_\_\_Monthly (2 points)

## \_\_\_Weekly (3 points)

## \_\_\_Daily or almost daily (4 points)

## 4. How often during the last year have you found that you were not able to stop drinking once you had started?

## \_\_\_Never (0 points)

## \_\_\_Less than monthly (1 point)

## \_\_\_Monthly (2 points)

## \_\_\_Weekly (3 points)

## \_\_\_Daily or almost daily (4 points)

## 5. How often during the last year have you failed to do what was normally expected of you because of drinking?

## \_\_\_Never (0 points)

## \_\_\_Less than monthly (1 point)

## \_\_\_Monthly (2 points)

## \_\_\_Weekly (3 points)

## \_\_\_Daily or almost daily (4 points)

## 6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?

## \_\_\_Never (0 points)

## \_\_\_Less than monthly (1 point)

## \_\_\_Monthly (2 points)

## \_\_\_Weekly (3 points)

## \_\_\_Daily or almost daily (4 points)

## 7. How often during the last year have you had a feeling of guilt or remorse after drinking?

## \_\_\_Never (0 points)

## \_\_\_Less than monthly (1 point)

## \_\_\_Monthly (2 points)

## \_\_\_Weekly (3 points)

## \_\_\_Daily or almost daily (4 points)

## 8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

## \_\_\_Never (0 points)

## \_\_\_Less than monthly (1 point)

## \_\_\_Monthly (2 points)

## \_\_\_Weekly (3 points)

## \_\_\_Daily or almost daily (4 points)

## 9) Have you or someone else been injured as a result of your drinking?\*

## ­­\_\_\_No (0 points)

## \_\_\_Yes, but not in the last year (2 points)

## \_\_\_Yes, during the last year (4 points)

## 10. Has a relative, a friend, a doctor, or another health worker been concerned about your drinking or suggested you cut down?\*

## \_\_\_No (0 points)

## \_\_\_Yes, but not in the last year (2 points)

## \_\_\_Yes, during the last year (4 points)

## Initials: \_\_\_\_\_\_\_\_\_ Today's Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## The Drug Abuse Screening Test (DAST)

## Directions: The following questions concern information about your involvement with drugs. Drug abuse refers to (1) the use of prescribed or “over-the-counter” drugs in excess of the directions, and (2) any non-medical use of drugs. Consider the past year (12 months) and carefully read each statement. Then decide whether your answer is YES or NO and check the appropriate space. Please be sure to answer every question.

## 1. Have you used drugs other than those required for medical reasons? Yes No

## 2. Have you abused prescription drugs? Yes No

## 3. Do you abuse more than one drug at a time? Yes No

## 4. Can you get through the week without using drugs (other than those required for medical reasons)?

## Yes No

## 5. Are you always able to stop using drugs when you want to? Yes No

## 6. Do you abuse drugs on a continuous basis? Yes No

## 7. Do you try to limit your drug use to certain situations? Yes No

## 8. Have you had “blackouts” or “flashbacks” as a result of drug use? Yes No

## 9. Do you ever feel bad about your drug abuse? Yes No

## 10. Does your spouse/family ever complain about your involvement with drugs? Yes No

## 11. Do your friends or relatives know or suspect you abuse drugs? Yes No

## 12. Has drug abuse ever created problems between you and your spouse? Yes No

## 13. Has a family member ever sought help for problems related to your drug use? Yes No

## 14. Have you ever lost friends because of your use of drugs? Yes No

## 15. Have you neglected your family or missed work because of your use of drugs? Yes No

## 16. Have you ever been in trouble at work because of drug abuse? Yes No

## 17. Have you ever lost a job because of drug abuse? Yes No

## 18. Have you gotten into fights when under the influence of drugs? Yes No

## 19. Have you ever been arrested because of unusual behavior while under the influence of drugs?

## Yes No

## 20. Have you ever been arrested for driving while under the influence of drugs? Yes No

## 21. Have you engaged in illegal activities in order to obtain drug? Yes No

## 22. Have you ever been arrested for possession of illegal drugs? Yes No

## 23. Have you experienced withdrawal symptoms as a result of heavy drug intake? Yes No

## 24. Have you had medical problems as a result of your drug use(e.g., memory loss, hepatitis, convulsions, bleeding, etc.)? Yes No

## 25. Have you ever gone to anyone for help for a drug problem? Yes No

## 26. Have you ever been in a hospital for medical problems related to drug use? Yes No

## 27. Have you ever been in a treatment program specifically related to drug use? Yes No

## 28. Have you been treated as an outpatient for problems related to drug abuse? Yes No

## Initials: \_\_\_\_\_\_\_\_\_ Today's Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Modified Mini Screen (MMS)

## Please choose "Yes" or "No" for each question.

## 1. Have you been consistently depressed or down, most of the day, nearly every day, for the past two weeks? Yes No

## 2. In the past two weeks, have you been less interested in most things or less able to enjoy the things you used to enjoy most of the time? Yes No

## 3. Have you felt sad, low, or depressed most of the time for the last two years? Yes No

## 4. In the past month, did you think that you would be better off dead or wish you were dead?\*

## Yes No

## 5. Have you ever had a period of time when you were feeling up, hyper, or so full of energy or full of yourself that you got into trouble, or that other people thought you were not your usual self?(Do not consider times when you were intoxicated on drugs or alcohol.) Yes No

## 6. Have you ever been so irritable, grouchy, or annoyed for several days, that you had arguments, had verbal or physical fights, or shouted at people outside your family? Have you or others noticed that you have been more irritable or overreacted, compared to other people, even when you thought you were right to act this way? Yes No

## 7. Have you had one or more occasions when you felt intensely anxious, frightened, uncomfortable, or uneasy, even when most people would not feel that way? Did these intense feelings get to be their worst within ten minutes? (If the answer to both questions is “yes,” check “yes” ;otherwise check “no.”) Yes No

## 8. Do you feel anxious or uneasy in places or situations where you might have the panic-like symptoms we just spoke about? Or do you feel anxious or uneasy in situations where help might not be available or escape might be difficult? Examples: ● being in a crowd, ● standing in a line, ● being alone away from home or alone at home, ● crossing a bridge, ● traveling in a bus, train, or car? Yes No

## 9. Have you worried excessively or been anxious about several things over the past six months?(If you answer “no” to this question, answer “no” to Question 10 and proceed to Question 11.)

## Yes No

## 10. Are these worries present most days? Yes No

## 11. In the past month, were you afraid or embarrassed when others were watching you or when you were the focus of attention? Were you afraid of being humiliated? Examples: ● speaking in public, ● eating in public or with others, ● writing while someone watches, ● being in social situations.

## Yes No

## Continued on next page

## 12. In the past month, have you been bothered by thoughts, impulses, or images that you couldn’t get rid of that were unwanted, distasteful, inappropriate, intrusive, or distressing? Examples:● being afraid that you would act on some impulse that would be really shocking, ● worrying a lot about being dirty, contaminated, or having germs, ● worrying a lot about contaminating others, or that you would harm someone even though you didn’t want to, ● having fears or superstitions that you would be responsible for things going wrong, ● being obsessed with sexual thoughts, images, or impulses, ● hoarding or collecting lots of things, ● having religious obsessions.

## Yes No

## 13. In the past month, did you do something repeatedly without being able to resist doing it? Examples: ● washing or cleaning excessively, ● counting or checking things over and over, ● repeating, collecting, or arranging things, ● other superstitious rituals. Yes No

## 14. Have you ever experienced, witnessed, or had to deal with an extremely traumatic event that included actual or threatened death or serious injury to you or someone else? Examples: ● serious accidents, ● sexual or physical assault, ● terrorist attack, ● being held hostage, ● kidnapping, ● fire, ● discovering a body, ● sudden death of someone close to you, ● war, ● natural disaster.

## Yes No

## 15. Have you re-experienced the awful event in a distressing way in the past month? Examples:● dreams, ● intense recollections, ● flashbacks, ● physical reactions. Yes No

## 16. Have you ever believed that people were spying on you, or that someone was plotting against you, or trying to hurt you? Yes No

## 17. Have you ever believed that someone was reading your mind or could hear your thoughts, or that you could actually read someone’s mind or hear what another person was thinking?

## Yes No

## 18. Have you ever believed that someone or some force outside of yourself put thoughts in your mind that were not your own, or made you act in a way that was not your usual self? Or, have you ever felt that you were possessed? Yes No

## 19. Have you ever believed that you were being sent special messages through the TV, radio, or newspaper? Did you believe that someone you did not personally know was particularly interested in you? Yes No

## 20. Have your relatives/friends ever considered any of your beliefs strange or unusual?

## Yes No

## 21. Have you ever heard things other people couldn’t hear, such as voices? Yes No

## 22. Have you ever had visions when you were awake or have you ever seen things other people couldn’t see? Yes No

## Initials: \_\_\_\_\_\_\_\_\_ Today's Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_