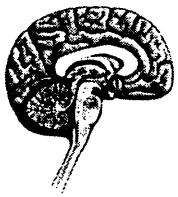

Birmingham Neuropsychology
Voice: (205) 329-7815, fax: 329-7816

Richard Azrin, Ph.D.
Cheryl Millsaps, Ph.D.

ADULT PATIENT INFORMATION FORM

CONFIDENTIAL

Instructions: Please complete this form as accurately and completely as you can. A doctor will discuss your responses with you.

Patient's Name Mr/Ms/Mrs _____ **Evaluation Date:**___/___/____ **Date of Birth:**___/___/____

Soc Sec Num:_____ Date form was completed:___/___/____ Who completed this form?_____

Address _____ Home Phone_____ Work/other Phone_____

Insurance Company_____ Policy #_____ Insured's Name:_____

Who referred you to this clinic? **(Full Name and Phone):**_____

When is your **next appointment** to see that referring doctor/ counselor? _____

Besides referral source, who else should get a copy of your report:_____

Patient's Age_____ **Gender (circle): Male Female** **Race:**_____ Are you right/left Handed? _____

Presenting or Current Problems

What difficulties, symptoms, or complaints do you have that led to your referral here?_____

Significant Symptoms

Please indicate whether you have ever experienced any of the symptoms below, when, and briefly describe:

Symptom	Circle Yes or No		When it began	Please briefly describe Problem(s) and Treatments, if any
Loss of Consciousness	No	Yes		
Memory Difficulties	No	Yes		
Weight Changes	No	Yes		
Chronic Pain	No	Yes		
Feeling Shaky	No	Yes		
Blurred/Double Vision	No	Yes		
Changes in ability to Smell	No	Yes		
Chronic Ringing in Ears	No	Yes		
Muscle Jerks or Twitches	No	Yes		
Bowel or Bladder Problems	No	Yes		
Speech Difficulties	No	Yes		
Sleep Difficulties	No	Yes		
Decreased Energy	No	Yes		
Decreased Motivation	No	Yes		
Decreased Happiness	No	Yes		
Social Isolation	No	Yes		
Frequent Headaches	No	Yes		
Dizziness	No	Yes		
Allergies	No	Yes		
Asthma	No	Yes		
Seizures	No	Yes		
High Fever	No	Yes		
Frequent Anxiety	No	Yes		
Persistently Depressed Mood	No	Yes		
Nightmares	No	Yes		
Angry Outbursts	No	Yes		
Mental Confusion	No	Yes		
Feelings of Paranoia	No	Yes		
Excessive Worry	No	Yes		
Unusual/Frightening Thoughts	No	Yes		

Diagnostic Examinations

Please describe results of any neurological tests/examinations of your brain:

	MRI	CT	Brain Scan or SPECT	EEG	Neurological Examination /Other
Approximate Date					
Describe results					

Other
(describe):_____

Medical History

Please describe briefly your **history of past and present serious illnesses** and treatment.

Past and present illnesses, diseases, syndromes	Dates (From - To)	Treatment (Surgery/Medication)	CurrentStatus

Do you suffer from:	High Blood Pressure	Diabetes	High Cholesterol	Other:_____
Treatment controlling it? (Yes No)				

Describe past **Accidents/Falls** leading to injury	Dates (From - To)	Surgery/Medications/Treatment

Describe any Other **Hospitalizations/Surgeries**	Dates (From - To)	Treatment (Surgery/Medication)	Current status

Activities of Daily Living

Do you currently hold a driver's license? **Yes** **No** (If No, how do you get around?)_____

If yes, are you currently driving? **Yes** **No** (if No, who drives you?)_____

Have your **driving** abilities worsened or become bad? (describe problems)_____ **No** **Yes**

Do you have trouble showering/dressing, cooking, cleaning, or remembering to take medicines or eat? **No** **Yes**

Have you left items on the stovetop or in the oven and forgotten them? **No** **Yes**

Does someone, other than yourself, manage your finances? (If yes, then who):_____ **No** **Yes**

Have thinking problems made you unable to pay bills, balance checkbook, invest, shop, make change? **No** **Yes**

What chores do you perform around the house?_____

What sorts of things do you do for fun? _____

Describe what you do and how often you spend time with family or friends relaxing or enjoying an entertaining or recreational activity?:_____

Describe how you get along with other people?_____

Current Medications

List names of Current Medications	Date medication prescribed	Dose (mg) (total per day)	Name of doctor who prescribed	What illness is medication for?	How well is this medication working

Alcohol Use

What type of alcohol (beer, vodka, wine) do you usually drink?_____ Are you currently drinking alcohol? **No** **Yes**

Total Number of Years drinking on a fairly regular basis_____ Have you ever had a drinking problem? **No** **Yes**

Average Amount you regularly drink (for example: 1 drink/week, 5 drinks/day, etc.) _____

Have you been involved in any treatment for: (circle) Drinking **Alcohol** (including A.A.) / Using **Drugs**: **No** **Yes**

Please list any current, recent or past drug use and any treatment for drug use:

Type of **Alcohol** or **Drug**	Average Amount Used per week	Describe any treatment?

Smoking

If you smoked previously, when did you stop?_____ Are you currently smoking? **No** **Yes**

Briefly describe attempts to quit smoking: _____

Approximately how many years smoked in lifetime: _____ Average number of packs/day _____

Psychological/Psychiatric

Have you ever had any treatment for psychiatric/psychological difficulties (relationship counseling psychological counseling, medicines for depression or anxiety, etc.): If yes, please describe below: **No** **Yes**

Problem	Date (From - To)	Describe Treatment received

Family Medical History

Please describe any family history of medical/neurological illness (Stroke, Alzheimer's, Dementia, High Blood Pressure) (include medical problems in all of your blood relatives, including psychiatric or psychological problems)

_____

_____

_____

Education

Last grade completed?_____ At what age?_____ Usual grades (A,B,C,D,F) in school?_____

Did you get a GED? **No** **Yes** Or did you get a high school diploma? **No** **Yes**

Did you ever repeat a grade? If yes, which grade(s)?_____ **No** **Yes**

Have you ever been enrolled in special education or learning disability classes? **No** **Yes**

If Yes, please describe:_____

List degrees beyond high school (medical, associate, bachelors, masters, doctorate, etc.)?_____ in _____

From what colleges _____

Please list any technical training or college education you have received since high school:

_____

Have you taken intelligence, cognitive, achievement, or neuropsychological tests in the past? **No** **Yes**

If Yes, please describe:_____

Vocational History

Are you currently working? **Yes** **No** (please list past jobs, even if not presently working)

Please outline your recent vocational history **beginning with your most recent (or current) employment**:

Dates (began – ended)	Company Name	Job Title	Describe your duties	Why did you leave?
Start here with most recent job 1. --				
2. --				
3. --				
4. --				

Are you currently **receiving** any type of **disability** income? If Yes, please explain:_____ **No** **Yes**

Are you currently in the process of **applying for disability** income?(SSI or others) explain?_____ **No** **Yes**

Have you ever been arrested for anything (if yes, describe) _____ **No** **Yes**

Have you ever served in the military? If yes, please complete the following: **No** **Yes**

Dates	Branch	Highest rank	Type of discharge	Combat duty (Y/N)

Marital Status (circle)? **Widowed** **Single** **Separated** **Divorced** **Married**

Spouse's name	Age when you married?	How long did you remain married?	Describe how you get along with that person now: (Good, Bad, No Contact, etc.)
1st:			
2nd:			
3rd:			
4th:			
Current spouse:			

Who currently lives with you? _____

Family

For the following family members please list their **age, education, occupation, and how well you get along:**

Relation	Name	Age	lives with you? **Yes/No**	Highest Grade Completed	Occupation	How well do you get along (good, bad, etc.)	List Health Problems
Spouse							
Children							
Mother							
Father							
Brothers and Sisters							
Other family members							

STOP, Please do not write below this line!

Who was present for this interview: Patient Who else:_____

Authorization to Obtain and Release Records:

Birmingham Neuropsychology LLC, 2018 Brookwood Medical Center Dr., Prof Ofc Bldg #310
Richard L Azrin, Ph.D. and Cheryl Millsaps, Ph.D. Voice: (205) 877-2956, Fax: (205) 877-2878

Patient Name: _____ Date of Birth: _____

Social Sec. #_____ Date(s) of requested records: _____

I hereby authorize the above providers to obtain and release the protected information specified below.

Please list any restrictions on this release of information_____

Name_____ Phone_____ Fax_____

Address_____

City State Zip

Name_____ Phone_____ Fax_____

Address_____

City State Zip

Name_____ Phone_____ Fax_____

Address_____

City State Zip

Name_____ Phone_____ Fax_____

Address_____

City State Zip

Name_____ Phone_____ Fax_____

Address_____

City State Zip

Records to be Obtained: Please send copies of all EEG, MRI, CT, History and Physical, and progress notes.

Release: This form when completed and signed by you, authorizes me to release, as well as to obtain, protected information from your clinical record to/from the person(s) you designate. I hereby authorize Dr. Richard L Azrin and Dr. Cheryl Millsaps and his/her administrative and clinical staff to release any and all contents of my chart (including at least billing information, psychotherapy/progress notes, test results/data, reports, visit information, prescriptions, medical information, documents provided by patient, insurance/third party forms/reports, records received by others). This information may be released to and/or obtained from the above individuals and my referral source. Providers and staff residing in 2018 Brookwood Med Center Dr. POB 310-311 may also obtain and release my information between each other. I am requesting my provider release this information to aid in treatment, assessment, and/or provide information about me to others. This authorization shall remain in effect for 7 years from the date signed. However, you have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that my provider generally may not condition mental health services upon my signing an authorization unless the services are provided to me for the purpose of creating health information for a third party. I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule. I hereby release the above treatment/assessment providers and their respective medical staff and office from any and all liability and claims arising out of or relating to the disclosure and/or release of confidential and/or privileged information.

_____ _____ _____

Name of patient and/or responsible party Signature of patient or responsible party Date

_____

If signed by patient's representative, please print representative's name and describe representative's authority to act for the patient

***** Please FAX records to Fax# (205) 877-2878 *****

New Patient Information

Name (Last)_____(First)_____(M.I.)_____

Address_____ City_____ State_____ Zip_____

Marital Status_____ Sex: **M** **F** Employer _____

Birth Date_____ Age_____ Social Security#_____

Home Phone (___)_____-_____ Work (___)_____-_____ Cell (___)_____-_____

Closet Relative not living with you_____ Home Phone (____)_____-_____

Address_____ City_____ State_____ Zip_____

Person Responsible for Payment (complete only if different from above)

Name_____ Relationship_____ Employer_____

Home Phone (_____)_____-_____ Work Phone (_____)_____-_____

Insurance Information

Name of Primary Insurance_____

Contract #_____ Group #_____ Effective Date_____

Request for Confidential Handling of Health Information:

Complete only if you want communications regarding your health care information sent to an alternate address or telephone other than listed above. I request that my provider handle my confidential health information as described below. All reasonable requests to receive communication of your health information by alternative means and/or locations will be granted. Please describe the alternative means below (e.g. US mail, telephone call, etc.) by which you prefer to receive your health information.

_____
(Alternate Address) (City) (State) (Zip)

_____ _____
Alternate Telephone Alternate Telephone

AGREEMENT

If Your Insurance Company OR Health Plan Requires Pre-approval OR Referral For Your Visit, it is YOUR responsibility to obtain this referral or YOU Will Be Personally Responsible for the bill. I, the undersigned (patient or legal guardian), authorize medical treatment to be rendered by the provider and assume financial responsibility. In the event the account is **not paid in full within 90 days*,** the undersigned agrees to pay all costs of collection including reasonable attorney fees, and hereby waives all rights of exemption under the constitution and laws of the State of Alabama. I also authorize the release of my medical records to my physicians and insurance carriers. If the provider has a contractual arrangement with your insurance carrier, the balance refers only to the amount that you are required to pay. I understand that all of the providers in the offices at 2018 Brookwood Med Center Dr., POB 310 and POB 311 are independent practitioners (not partners) although they are sharing office and staff. Your signature below also indicates you have received the Alabama Notice Form: Notice of Polices and Practices to Protect the Privacy of your Health Information and agree to its terms and serves as an acknowledgement that you have been given a copy of the HIPAA Notice Form.

Signature of Patient or Responsible party _____ Date_____

If signed by a Responsible party, describe that representative's authority to act for the patient _____

Please print your answers.

ADULT SELF-REPORT FOR AGES 18-59

For office use only
ID#

YOUR FULL NAME First Middle Last

YOUR GENDER ☐ Male ☐ Female

YOUR AGE

ETHNIC GROUP OR RACE

TODAY'S DATE Mo.____ Date ____ Yr. ____

YOUR BIRTHDATE Mo.____ Date ____ Yr.____

Please fill out this form to reflect ***your*** views, even if other people might not agree. You need not spend a lot of time on any item. Feel free to print additional comments. ***Be sure to answer all items.***

YOUR USUAL TYPE OF WORK, even if not working now. Please be specific—for example, auto mechanic; high school teacher; homemaker; laborer; lathe operator; shoe salesman; army sergeant; student (indicate what you are studying & what degree you expect).

Your work _____ Spouse or partner's work _____

PLEASE CHECK YOUR HIGHEST EDUCATION

- ☐ 1. No high school diploma and no GED
- ☐ 2. General Equivalency Diploma (GED)
- ☐ 3. High school graduate
- ☐ 4. Some college but no college degree
- ☐ 5. Associate's Degree
- ☐ 6. Bachelor's or RN Degree
- ☐ 7. Some graduate school but no graduate degree
- ☐ 8. Master's Degree
- ☐ 9. Doctoral or Law Degree
- ☐ Other education (specify): _____

I. FRIENDS:

A. About how many close friends do you have? (Do not include family members.)

☐ **None** ☐ **1** ☐ **2 or 3** ☐ **4 or more**

B. About how many times a month do you have contact with any of your close friends? (Include in-person contacts, phone, letters, e-mail.)

☐ **Less than 1** ☐ **1 or 2** ☐ **3 or 4** ☐ **5 or more**

C. How well do you get along with your close friends?

☐ **Not as well as I'd like** ☐ **Average** ☐ **Above average** ☐ **Far above average**

D. About how many times a month do any friends or family visit you?

☐ **Less than 1** ☐ **1 or 2** ☐ **3 or 4** ☐ **5 or more**

II. SPOUSE OR PARTNER:

What is your marital status?

- ☐ **Never been married**
- ☐ **Married, living with spouse**
- ☐ **Widowed**
- ☐ **Married but separated from spouse**
- ☐ **Divorced**
- ☐ **Other—please describe:** _____

At any time in the past 6 months, did you live with your spouse or with a partner?

☐ **No—please skip to page 2.**

☐ **Yes**—Circle ***0, 1,*** or ***2*** beside items A-H to describe your relationship ***during the past 6 months:***

0 = Not True **1 = Somewhat or Sometimes True** **2 = Very True or Often True**

0	1	2	A. I get along well with my spouse or partner	0	1	2	E. My spouse or partner and I *disagree* about living arrangements, such as where we live
0	1	2	B. My spouse or partner and I have trouble sharing responsibilities	0	1	2	F. I have trouble with my spouse or partner's family
0	1	2	C. I feel satisfied with my spouse or partner	0	1	2	G. I like my spouse or partner's friends
0	1	2	D. My spouse or partner and I enjoy similar activities	0	1	2	H. My spouse or partner's behavior annoys me

ASEBA, University of Vermont
1 South Prospect St., Burlington, VT 05401-3456
www.ASEBA.org

Please be sure you have answered all items.
Then see other side.

1-03 Edition - 111

III. FAMILY:

Compared with others, how well do you:		Worse than Average	Variable or Average	Better than Average	No Contact
A. Get along with your brothers?	☐ I have no brothers	☐	☐	☐	☐
B. Get along with your sisters?	☐ I have no sisters	☐	☐	☐	☐
C. Get along with your mother?	☐ Mother is deceased	☐	☐	☐	☐
D. Get along with your father?	☐ Father is deceased	☐	☐	☐	☐
E. Get along with your biological or adopted children?	☐ I have no children				
1. Oldest child	☐ Not applicable	☐	☐	☐	☐
2. 2nd oldest child	☐ Not applicable	☐	☐	☐	☐
3. 3rd oldest child	☐ Not applicable	☐	☐	☐	☐
4. Other children	☐ Not applicable	☐	☐	☐	☐
F. Get along with your stepchildren?	☐ I have no stepchildren	☐	☐	☐	☐

IV. JOB: ***At any time in the past 6 months,*** did you have any paid jobs (including self-employment and military service)?

☐ **No—please skip to Section V.**

☐ **Yes—please describe your job(s):** _____

Circle ***0, 1,*** or ***2*** beside items A-I to describe your work experience ***during the past 6 months:***

0 = Not True **1 = Somewhat or Sometimes True** **2 = Very True or Often True**

0 1 2	A. I work well with others	**0 1 2**	F. I do things that may cause me to lose my job
0 1 2	B. I have trouble getting along with bosses	**0 1 2**	G. I stay away from my job even when I'm not sick or not on vacation
0 1 2	C. I do my work well	**0 1 2**	H. My job is too stressful for me
0 1 2	D. I have trouble finishing my work	**0 1 2**	I. I worry too much about work
0 1 2	E. I am satisfied with my work situation		

V. EDUCATION: ***At any time in the past 6 months,*** did you attend school, college, or any other educational or training program?

☐ **No—please skip to Section VI.**

☐ **Yes**—what kind of school or program? _____

What degree or diploma are you seeking? _____ Major? _____

When do you expect to receive your degree or diploma? _____

Circle ***0, 1,*** or ***2*** beside items A-E to describe your educational experience ***during the past 6 months:***

0 = Not True **1 = Somewhat or Sometimes True** **2 = Very True or Often True**

0 1 2	A. I get along well with other students	**0 1 2**	D. I am satisfied with my educational situation
0 1 2	B. I achieve what I am capable of	**0 1 2**	E. I do things that may cause me to fail
0 1 2	C. I have trouble finishing assignments		

VI. Do you have any illness, disability, or handicap? ☐ **No** ☐ **Yes—please describe:**

VII. Please describe your concerns or worries about family, work, education, or other things: ☐ **No concerns**

VIII. Please describe the best things about yourself:

IX. Below is a list of items that describe people. For each item, please circle *0, 1,* or *2* to describe yourself *over the past 6 months.* Please answer all items as well as you can, even if some do not seem to apply to you.

0 = Not True **1 = Somewhat or Sometimes True** **2 = Very True or Often True**

0 1 2 1. I am too forgetful
0 1 2 2. I make good use of my opportunities
0 1 2 3. I argue a lot
0 1 2 4. I work up to my ability
0 1 2 5. I blame others for my problems
0 1 2 6. I use drugs (other than alcohol and nicotine) for nonmedical purposes (describe): _____
_____
0 1 2 7. I brag
0 1 2 8. I have trouble concentrating or paying attention for long
0 1 2 9. I can't get my mind off certain thoughts (describe): _____
_____
0 1 2 10. I have trouble sitting still
0 1 2 11. I am too dependent on others
0 1 2 12. I feel lonely
0 1 2 13. I feel confused or in a fog
0 1 2 14. I cry a lot
0 1 2 15. I am pretty honest
0 1 2 16. I am mean to others
0 1 2 17. I daydream a lot
0 1 2 18. I deliberately try to hurt or kill myself
0 1 2 19. I try to get a lot of attention
0 1 2 20. I damage or destroy my things
0 1 2 21. I damage or destroy things belonging to others
0 1 2 22. I worry about my future
0 1 2 23. I break rules at work or elsewhere
0 1 2 24. I don't eat as well as I should
0 1 2 25. I don't get along with other people
0 1 2 26. I don't feel guilty after doing something I shouldn't
0 1 2 27. I am jealous of others
0 1 2 28. I get along badly with my family
0 1 2 29. I am afraid of certain animals, situations, or places (describe): _____
_____
0 1 2 30. My relations with the opposite sex are poor
0 1 2 31. I am afraid I might think or do something bad
0 1 2 32. I feel that I have to be perfect
0 1 2 33. I feel that no one loves me
0 1 2 34. I feel that others are out to get me
0 1 2 35. I feel worthless or inferior
0 1 2 36. I accidentally get hurt a lot, accident-prone
0 1 2 37. I get in many fights
0 1 2 38. My relations with neighbors are poor
0 1 2 39. I hang around people who get in trouble
0 1 2 40. I hear sounds or voices that other people think aren't there (describe): _____
_____
0 1 2 41. I am impulsive or act without thinking
0 1 2 42. I would rather be alone than with others
0 1 2 43. I lie or cheat
0 1 2 44. I feel overwhelmed by my responsibilities
0 1 2 45. I am nervous or tense
0 1 2 46. Parts of my body twitch or make nervous movements (describe): _____
_____
0 1 2 47. I lack self-confidence
0 1 2 48. I am not liked by others
0 1 2 49. I can do certain things better than other people
0 1 2 50. I am too fearful or anxious
0 1 2 51. I feel dizzy or lightheaded
0 1 2 52. I feel too guilty
0 1 2 53. I have trouble planning for the future
0 1 2 54. I feel tired without good reason
0 1 2 55. My moods swing between elation and depression
56. Physical problems ***without known medical cause:***
0 1 2 a. Aches or pains (***not*** stomach or headaches)
0 1 2 b. Headaches
0 1 2 c. Nausea, feel sick
0 1 2 d. Problems with eyes (***not*** if corrected by glasses) (describe): _____
_____
0 1 2 e. Rashes or other skin problems
0 1 2 f. Stomachaches
0 1 2 g. Vomiting, throwing up
0 1 2 h. Heart pounding or racing
0 1 2 i. Numbness or tingling in body parts
0 1 2 57. I physically attack people
0 1 2 58. I pick my skin or other parts of my body (describe): _____
_____
0 1 2 59. I fail to finish things I should do
0 1 2 60. There is very little that I enjoy
0 1 2 61. My work performance is poor
0 1 2 62. I am poorly coordinated or clumsy

Please be sure you have answered all items. Then see other side.

Please print your answers. Be sure to answer all items.

0 = Not True **1 = Somewhat or Sometimes True** **2 = Very True or Often True**

0 1 2 63. I would rather be with older people than with people of my own age
0 1 2 64. I have trouble setting priorities
0 1 2 65. I refuse to talk
0 1 2 66. I repeat certain acts over and over (describe): _____
_____
0 1 2 67. I have trouble making or keeping friends
0 1 2 68. I scream or yell a lot
0 1 2 69. I am secretive or keep things to myself
0 1 2 70. I see things that other people think aren't there (describe): _____
_____
0 1 2 71. I am self-conscious or easily embarrassed
0 1 2 72. I worry about my family
0 1 2 73. I meet my responsibilities to my family
0 1 2 74. I show off or clown
0 1 2 75. I am too shy or timid
0 1 2 76. My behavior is irresponsible
0 1 2 77. I sleep more than most other people during day and/or night (describe):
_____
0 1 2 78. I have trouble making decisions
0 1 2 79. I have a speech problem (describe):
_____
0 1 2 80. I stand up for my rights
0 1 2 81. My behavior is very changeable
0 1 2 82. I steal
0 1 2 83. I am easily bored
0 1 2 84. I do things that other people think are strange (describe): _____
_____
0 1 2 85. I have thoughts that other people would think are strange (describe): _____
_____
0 1 2 86. I am stubborn, sullen, or irritable
0 1 2 87. My moods or feelings change suddenly
0 1 2 88. I enjoy being with people
0 1 2 89. I rush into things without considering the risks
0 1 2 90. I drink too much alcohol or get drunk
0 1 2 91. I think about killing myself
0 1 2 92. I do things that may cause me trouble with the law (describe): _____
_____
0 1 2 93. I talk too much
0 1 2 94. I tease others a lot
0 1 2 95. I have a hot temper
0 1 2 96. I think about sex too much
0 1 2 97. I threaten to hurt people
0 1 2 98. I like to help others
0 1 2 99. I dislike staying in one place for very long
0 1 2 100. I have trouble sleeping (describe): _____
_____
0 1 2 101. I stay away from my job even when I'm not sick or not on vacation
0 1 2 102. I don't have much energy
0 1 2 103. I am unhappy, sad, or depressed
0 1 2 104. I am louder than others
0 1 2 105. People think I am disorganized
0 1 2 106. I try to be fair to others
0 1 2 107. I feel that I can't succeed
0 1 2 108. I tend to lose things
0 1 2 109. I like to try new things
0 1 2 110. I wish I were of the opposite sex
0 1 2 111. I keep from getting involved with others
0 1 2 112. I worry a lot
0 1 2 113. I worry about my relations with the opposite sex
0 1 2 114. I fail to pay my debts or meet other financial responsibilities
0 1 2 115. I feel restless or fidgety
0 1 2 116. I get upset too easily
0 1 2 117. I have trouble managing money or credit cards
0 1 2 118. I am too impatient
0 1 2 119. I am not good at details
0 1 2 120. I drive too fast
0 1 2 121. I tend to be late for appointments
0 1 2 122. I have trouble keeping a job
0 1 2 123. I am a happy person

124. ***In the past 6 months,*** about how many times per day did you use tobacco (including smokeless tobacco)? _____ times per day.

125. ***In the past 6 months,*** on how many days were you drunk? _____ days.

126. ***In the past 6 months,*** on how many days did you use drugs for nonmedical purposes (including marijuana, cocaine, and other drugs, except alcohol and nicotine)? _____ days.

Please be sure you have answered all items.

Please print your answers.

ADULT BEHAVIOR CHECKLIST FOR AGES 18-59

For office use only
ID#

ADULT'S FULL NAME First Middle Last

ADULT'S GENDER ☐ Male ☐ Female

ADULT'S AGE

ETHNIC GROUP OR RACE

TODAY'S DATE Mo. ____ Date ____ Yr. ____

ADULT'S BIRTHDATE Mo. ____ Date ____ Yr. ____

PLEASE CHECK ADULT'S HIGHEST EDUCATION

☐ 1. No high school diploma and no GED
☐ 2. General Equivalency Diploma (GED)
☐ 3. High school graduate
☐ 4. Some college but no college degree
☐ 5. Associate's Degree
☐ 6. Bachelor's or RN Degree
☐ 7. Some graduate school but no graduate degree
☐ 8. Master's Degree
☐ 9. Doctoral or Law Degree
☐ Other education (specify):

ADULT'S USUAL TYPE OF WORK, even if not working now. Please be specific—for example, auto mechanic; high school teacher; homemaker; laborer; lathe operator; shoe salesman; army sergeant; student (indicate what he/she is studying & what degree is expected).

Adult's work ____ Spouse or partner's work ____

THIS FORM FILLED OUT BY (print your full name):

____

Your relationship to adult:

☐ Spouse ☐ Partner ☐ Other (specify): ____

Please fill out this form to reflect ***your*** views, even if other people might not agree. You need not spend a lot of time on any item. Feel free to print additional comments. ***Be sure to answer all items.***

I. FRIENDS:

A. About how many close friends does he/she have? (Do not include family members.)

☐ **None** ☐ **1** ☐ **2 or 3** ☐ **4 or more**

B. About how many times a month does he/she have contact with any close friends? (Include in-person contacts, phone, letters, e-mail.)

☐ **Less than 1** ☐ **1 or 2** ☐ **3 or 4** ☐ **5 or more**

C. How well does he/she get along with close friends?

☐ **Not well** ☐ **Average** ☐ **Above average** ☐ **Far above average**

D. About how many times a month do any friends or family visit him/her?

☐ **Less than 1** ☐ **1 or 2** ☐ **3 or 4** ☐ **5 or more**

II. SPOUSE OR PARTNER:

What is his/her marital status?

☐ **Never been married**
☐ **Married but separated from spouse**
☐ **Married, living with spouse**
☐ **Divorced**
☐ **Widowed**
☐ **Other—please describe:** ____

At any time in the past 6 months, did he/she live with a spouse or partner?

☐ **No—please skip to page 2.**

☐ **Yes**—Circle ***0, 1,*** or ***2*** beside items A-H to describe his/her relationship ***during the past 6 months:***

0 = Not True (as far as you know) 1 = Somewhat or Sometimes True 2 = Very True or Often True

0 1 2 A. Gets along well with spouse or partner

0 1 2 B. Has trouble sharing responsibilities with spouse or partner

0 1 2 C. Seems satisfied with spouse or partner

0 1 2 D. Enjoys similar activities as spouse or partner

0 1 2 E. Disagrees with spouse or partner about living arrangements, such as where to live

0 1 2 F. Has trouble with spouse or partner's family

0 1 2 G. Likes spouse or partner's friends

0 1 2 H. Is annoyed by spouse or partner's behavior

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Please be sure you have answered all items.
Then see other side.

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III. Does he/she have any illness, disability, or handicap? ☐ **No** ☐ **Yes—please describe:**

IV. Please describe any concerns you have about him/her: ☐ **No concerns**

V. Please describe the best things about him/her:

Please be sure you have answered all items.