

ANXIETY MANAGEMENT PROGRAM INITIAL EVALUATION

Welcome to the Anxiety Management Program at Kaiser Redwood City. Your initial evaluation will have 2 important parts. The first part is a series of questionnaires we need you to fill out, and the second part is an interview with one of the professional staff.

The Purpose of the Questionnaires

The purpose of having you fill out these questionnaires is to get information that we can use to understand your problems and plan your treatment. These questionnaires will tell the clinician about the things that are bothering you now, including your physical health, emotional difficulties, and bodily symptoms. The goal of this is to enable the clinician to get to know you as well as possible, in order to select and plan the most appropriate treatment.

General Instructions

Please fill out these questionnaires in order. If there are any problems or questions or concerns you have about any of the items, make a note to mention these to the clinician. Please answer every question unless there are specific instructions to skip an item.

PERSONAL DATA SHEET

Name: _____

Occupation: _____

How long? _____

Kaiser MR#: _____

Present Employer: _____

How long? _____

Today's date: _____

Usual work hours: _____

Date of Birth: _____

Birthplace: _____

Age: _____ Gender: _____

How long lived in this area? _____

Address: _____

Last school grade completed: _____

City: _____

Phone(s): home: _____ ok to call? _____

Religion: _____

work: _____ ok to call? _____

Military Service: _____

cell: _____ ok to call? _____

Emergency Contact: _____

Race/ethnicity? _____

Phone: _____

Sexual orientation:

Check One:

- Single, never married Divorced
- Married Widow(er)
- Separated Living with partner

- Heterosexual Transgender
- Homosexual Questioning
- Bisexual

If married or living with partner, how long? _____

Do you have a work-related problem? yes no

Are you currently on:

Worker's Compensation? yes no

SSI? yes no

State Disability? yes no

If married before, please list dates of marriage and how each marriage ended (divorce, death, annulment) :

1st marriage: _____ to _____ How ended? _____

2nd marriage: _____ to _____ How ended? _____

3rd marriage: _____ to _____ How ended? _____

Do you want to initiate disability claim now? yes no

Have you had any financial problems? yes no

Any legal difficulties or prior imprisonment? yes no

CURRENT CONCERNS:

Who referred you to the Psychiatry Clinic? _____

Types of help desired (check all that apply):

- Medication Therapy Individual Counseling/Therapy Substance Abuse Treatment
- Group Therapy Family Therapy Couples Therapy
- Other: _____

What specific event made you decide to pick up the phone and call for this appointment?

What is the **PRIMARY PROBLEM** for which you are seeking help right now? Please be specific:

When did this problem or the symptoms begin? _____

How often do the symptoms occur? _____

What have you tried so far to resolve this problem? _____

PAST PSYCHIATRIC TREATMENT

Have you ever had any counseling or psychotherapy before, for this or ANY reason? yes no

<u>Year (approx)</u>	<u>Type (individual, family, group)?</u>	<u>By Whom</u>	<u>Duration</u>	<u>Helpful? (Y or N)</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Have you **ever** had used any psychiatric medication for any reason, such as tranquilizers (e.g., Valium, Xanax, Ativan, Klonopin) or antidepressants (e.g., Elavil, Tofranil or Imipramine, Prozac, Zoloft, Paxil)? yes no

<u>Year (approx)</u>	<u>Name of medication</u>	<u>By Whom</u>	<u>Using Now?</u>	<u>Helpful? (Y or N)</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Have you ever been psychiatrically hospitalized? yes no

<u>Year (approx)</u>	<u>Where?</u>	<u>Why</u>	<u>Duration</u>	<u>Helpful? (Y or N)</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Have you ever had any allergic reactions or other problems with medications? yes no

If yes, which drugs? _____

Have you been having any thoughts about suicide? yes no

Have you been having any thoughts about hurting anyone else? yes no

What serious medical problems, illnesses, surgery, or injuries have you had? _____

In general, would you say your health is (circle one number):

Excellent Very Good Good Fair Poor
1 2 3 4 5

SUBSTANCE USE

How much caffeine do you drink every day? _____ cups (5-6 oz.) OR _____ mugs (10-12 oz.)

How much tobacco products do you use every day? _____

How much alcohol do you drink every day? _____ per week _____

Do you use any kind of street drugs? yes no Did you use street drugs in the past? yes no

If yes, what kind? _____

How much? _____

Last drug use (time and amount)? _____

Do you feel you have a problem with alcohol? yes no

with other drugs? yes no

FAMILY DATA SHEET

Name	City of Residency	Age	If deceased, age/yr of death	Marital Status	Occupation	How do/did you get along?
Spouse:						
Children:						
Others living in household now:						
Father:						
Mother:						
Stepparents:						
Sisters and Brothers:						

Have relatives/significant others had psychiatric symptoms or drug or alcohol problems? yes no

Relative	Symptoms or Problems	Treatment	Psychiatric Meds	Psychiatric Hospitalizations

SYMPTOMS

Please check items below that apply to your current and past conditions(s):

	<i>Now</i>	<i>Past</i>		<i>Now</i>	<i>Past</i>		<i>Now</i>	<i>Past</i>
Headaches			Excess energy/"wired"			Concentration problems		
Dizziness			Elated/euphoric mood			Confusion		
Stomach/bowel trouble			Excessive spending			Memory problems		
Pain			Racing/overflow of thoughts					
Tremors or tics			Irritable			Someone physically harming you		
Health problems			Impulsive behaviors—specify: _____			Thoughts of physically harming someone else		
Drug cravings			Self-harm behaviors			Financial problems		
Alcohol cravings			Grandiose thoughts or plans			Conflict in family		
			Anger or explosiveness			Violent/aggressive behavior		
Eating problems			Decreased need for sleep			Physical abuse		
Binge Eating			Mood swings			Sexual abuse		
Sleep problems						Sexual problems		
Weight loss			Panic attacks			Relationship problems		
Weight gain			Anxiety					
Loss of appetite			Fears			Hear voices others don't hear		
			Nightmares			See things others don't see		
Feeling apart from others			Fears of losing self-control			Strange experiences		
Low energy			Recurring unwanted thoughts			Feel people plot against you		
Feeling worthless			Recurring unwanted behaviors			Constant suspicion/distrust		
Feeling depressed			Always worried			Unusual thoughts		
Crying a lot								
Unable to have good time			Thoughts of suicide					
Restlessness			Planning suicide					
			Attempted suicide					

Please rate each item by circling one of the five phrases for each statement. Please answer every item:

1. It scares me when I feel shaky. 0 ————— 1 ————— 2 ————— 3 ————— 4
 Very little A little Some Much Very Much

2. It scares me when I feel faint. 0 ————— 1 ————— 2 ————— 3 ————— 4
 Very little A little Some Much Very Much

3. It scares me when my heart beats rapidly. 0 ————— 1 ————— 2 ————— 3 ————— 4
 Very little A little Some Much Very Much

4. It scares me when I become short of breath. 0 ————— 1 ————— 2 ————— 3 ————— 4
 Very little A little Some Much Very Much

In the past year, have you had 2 weeks or more during which you felt sad, blue or depressed; or when you lost all interest or pleasure in things that you usually cared about or enjoyed? ___yes ___no

Have you had 2 years or more in your life when you felt depressed or sad most days, even if you felt okay sometimes? ___yes ___no

Have you felt depressed or sad much of the time in the past year? ___yes ___no

1. Have you ever had times when you felt a sudden rush of intense fear or impending doom, accompanied by a number of physical symptoms? This would be similar to the "adrenalin rush" you might have if there was a sudden accident right in front of you on the freeway, like an alarm going off in your body.

yes no

2. These sudden rushes off fear are called **PANIC ATTACKS**. In what situations have you had these feelings? (e.g., in lines, restaurants, supermarkets, driving, heights, near animals, etc.)

3. Have you ever had these feelings seem to come out of nowhere, "from out of the blue," or in situations where you did not expect them to occur?

yes no

4. Since your first panic attack, have you become concerned or afraid of having more of these attacks, or worried about their consequences (e.g., losing control or having a heart attack, or going crazy)?

yes no

5. Do you or have you ever avoided an activity or situation for fear that you might have more attacks?

yes no

Please indicate the number of panic attacks you have had in the last 7 days. _____

Now let's change our focus away from panic attacks. Instead, we'd like to know about **WORRIES** that do not have anything to do with panic attacks.

6. What kinds of things do you worry about besides panic attacks? (e.g., work or school, finances, family, health, etc.)

7. Do you think you worry excessively (about things other than panic)? yes no
That is, are you a worrier?

8. Do others think you worry excessively? yes no

9. Do you worry excessively over minor matters? yes no

10. Do you have trouble turning off your worry? yes no

11. Do you worry more days than not? yes no

12. Do you sometimes worry so much that you get physical symptoms?
(Check all that apply):

- Difficulty sleeping
- Muscle tension
- Restlessness, feeling keyed up or on edge
- Easily fatigued
- Trouble concentrating, mind going blank

13. How much does your worrying interfere with your life, work, social activities, family, etc.?

0-----1-----2-----3-----4
None Mildly Moderately Severely Extremely

14. Sometimes things happen to people that are extremely upsetting—things like being in a life-threatening situation like a major disaster, very serious accident or fire; being physically assaulted or raped; seeing another person killed or dead, or badly hurt; or hearing about something horrible that has happened to someone you are close to. At any time in your life, have any of these kinds of things happened to you? yes no

If yes:

What happened? _____

When did it occur? (How old were you?) _____

In the past month, have you:

Had nightmares about it or thought about it when you did not want to? yes no

Tried hard not to think about it or went out of your way to avoid situations that reminded you of it? yes no

Were constantly on guard, watchful, or easily startled? yes no

Felt numb or detached from others, activities, or your surroundings? yes no

15. Are you bothered by thoughts or images or urges that are persistent and seem inappropriate to you but that keep intruding into your mind? Thoughts or images that don't fit with your perception of yourself, but keep coming into your mind in spite of yourself?

(This is not the same as normal worrying about real-life problems. We mean things that are very repetitive, the same sort of thought or image intruding over and over again, which may seem strange or even bizarre, like repetitive thoughts about hurting or poisoning someone, or being contaminated or infected or dirty, or shouting obscenities in public, or acting in a sexually inappropriate way, for example.)

yes no

16. If you have this kind of unusual yet obsessive thought or image or urge, do you try to get rid of it, or try to suppress it or neutralize it with some other thought or action? yes no

If yes, please specify what you do: _____

17. Have you felt compelled to repeat some act over and over again that doesn't seem to make sense and that you don't want to do? For example, washing your hands or some object over and over again? Or folding or organizing repeatedly, or counting, or saying certain phrases over and over? Or perhaps checking something repeatedly such as locked doors, important papers, or retracing driving routes?

yes no

If yes, do you try to resist doing the repetitive act, or did you resist initially?

yes no

If yes, please specify what you do: _____

18. How much are you bothered by the problems described in questions 14 or 15 or 16? (Circle one)

0-----1-----2-----3-----4
None Mildly Moderately Severely Extremely

19. How much do these problems interfere with your life?

0-----1-----2-----3-----4
None Mildly Moderately Severely Extremely

20. How much of the living area in your home is cluttered with possessions? (Consider the amount of clutter in your kitchen, living room, dining room, hallways, bedrooms, bathrooms, or other rooms.)

0-----1-----2-----3-----4
None A little A moderate Most/much Almost all/
amount Complete

21. To what extent do you have difficulty throwing things away?

0-----1-----2-----3-----4
None Mild Moderate Considerable/
Severe Extreme

22. How often do you feel compelled to acquire something you see? (e.g., when shopping or offered free things?)

0-----1-----2-----3-----4
Never Rarely Sometimes/
Occasionally Frequently
Often Very Often

23. In **social** or public situations where you might be observed or scrutinized or evaluated by others, do you feel nervous, anxious, or panicky? yes no

24. Are you overly concerned that you might act in a way that will be humiliating or embarrassing, or that others will see your anxiety symptoms? yes no

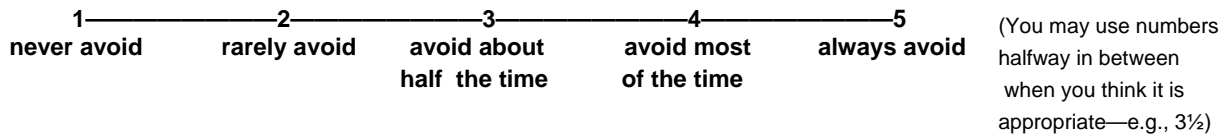
25. How much do you fear and avoid the following situations? Please fill in BOTH columns completely, giving separate ratings for fear and avoidance. Use this 10-point scale for each rating of fear, and each rating of avoidance.

0———1———2———3———4———5———6———7———8———9———10
 No fear/ mild fear/ moderate fear/ severe fear/ extreme fear/
 Never avoid rarely avoid sometimes avoid often avoid always avoid

	Fear	Avoidance
Eating or drinking when other people might be watching.	_____	_____
Being watched or stared at	_____	_____
Talking to people in authority	_____	_____
Speaking in front of a group of people in a work setting	_____	_____
Speaking in front of a group of people in a non-work setting,	_____	_____
Parties (with family, or friends, or a largely unfamiliar group)	_____	_____
Meetings	_____	_____
Writing in public (e.g., signing checks, filling out forms)	_____	_____
Using public restrooms	_____	_____
Dating situations	_____	_____
Initiating a conversation in a social or work situation	_____	_____
Maintaining a conversation in a social or work situation	_____	_____

26. Were you ever afraid of going out of the house alone, being in crowds, standing in a line, or traveling on buses or trains? yes no If yes, please answer the questions on this page:

Instructions: Please indicate the degree to which you avoid the following places or situations because of discomfort or anxiety. Rate your amount of avoidance when you are with a trusted companion and when you are alone. Do this by using the following scale.



Write your score in the blanks for each situation or place under both conditions: when accompanied. and when alone. Leave blank those situations that do not apply to you. Remember to fill out both columns for each item that does apply to you.

	<u>When Accompanied</u>	<u>When Alone</u>
Theaters	_____	_____
Supermarkets	_____	_____
Classrooms	_____	_____
Department Stores	_____	_____
Restaurants	_____	_____
Museums	_____	_____
Elevators	_____	_____
Auditoriums or stadiums	_____	_____
Churches or synagogues	_____	_____
Parking Garages	_____	_____
High Places	_____	_____
Tell how high _____	_____	_____
Enclosed spaces (e.g. tunnels)	_____	_____
Open spaces:	_____	_____
Outside (e.g., fields, wide streets, courtyards)	_____	_____
Inside (e.g., large rooms, lobbies)	_____	_____
<u>Riding in:</u>	_____	_____
Buses	_____	_____
Trains	_____	_____
Subways	_____	_____
Airplanes	_____	_____
Boats	_____	_____
<u>Driving or riding in car</u>	_____	_____
At any time	_____	_____
On expressways	_____	_____
Across bridges	_____	_____
<u>Situations</u>	_____	_____
Standing in lines	_____	_____
Parties or social gatherings	_____	_____
Walking on the street	_____	_____
Staying at home alone	N/A	_____
Being far away from home	_____	_____
<u>Other:</u> _____	_____	_____
_____	_____	_____
_____	_____	_____