Johns Hopkins Anxiety Disorders Clinic
Intake Evaluation Questionnaire Packet

As part of your visit at the Johns Hopkins Anxiety Disorders Clinic, we ask that you complete the enclosed questionnaire, addressing current difficulties, your goals for the evaluation, and background information. We ask that you complete this form before your appointment so that your doctor can read it. This information will be kept confidential, only available to Anxiety Clinic staff members. Please bring your completed packet with you to your appointment.

Demographic and Contact Information

Name (Please print): ____
Date of Birth: ________________ Age: ______
Address: ____
____
Email: ____
Phone: ____
Preferred method of contact: ____

Do we have your permission to leave a message on your voicemail/answering machine saying where we are calling from? ______ Yes ______ No
If not, how would you prefer we get in touch with you? ___________________________
____

What ethnicity do you identify with? (Please ugrgevall that apply)

White	Native American
Black	Asian
Hispanic	Other (please specify ___________________________)

We are often involved in various anxiety-related research projects. May we have your permission to contact you about participating in future research projects? Please note that your response will have no bearing on your treatment at Johns Hopkins.
______ Yes ______ No ______ Not sure

History of Present Illness/Problem:

What is the main problem you would like help with?

What are your goals for this evaluation (e.g., second opinion, clarify diagnosis, treatment, etc.)?

When did the current problem begin (i.e., what was going on in your life at the time)?

____
____
____

What treatments for this have you tried in the past, if any?

____
____
____
____

What was the most successful treatment, if applicable?

____
____
____

Family History:

Mother: Living ______Deceased ______
If living, current age: ______ Current health: ____________________
If deceased, age at time of death: ______
How old were you at the time? ______
Cause of death: ____________________
Occupation: ____________________

Please give a description of your mother's (or mother substitute's) personality and your relationship (past and present):

____
____

Father: Living ______Deceased ______
If living, current age: ______ Current health: ____________________
If deceased, age at time of death: ______
How old were you at the time? ______
Cause of death: ____________________
Occupation: ____________________

Please give a description of your father's (or father substitute's) personality and your relationship (past and present):

____
____

Siblings: Number of brothers: ______ Age(s) of brothers: ______
Number of sisters: ______ Age(s) of sisters: ______
Your place in the family (e.g., 4th of 5 children): ______________________

Does any member of your family suffer from alcoholism, epilepsy, depression, anxiety, or anything else that might be considered a mental or nervous system problem? If yes, please describe:

____
____
____
____
____

Has any relative ever attempted or committed suicide?

____
____

Personal History:

Place of birth: ____

As far as you know, did you or your mother experience any health problems during her pregnancy with or delivery of you? If yes, please describe:

____
____
____

As far as you know, did you meet your developmental milestones on time (e.g., walking or talking)? Yes ______ No ______ If not, please describe:

____
____
____

Were you raised by your parents? Yes ______ No ______
If not, who raised you, and between what ages? ____
____

Growing up, how did you get along with your siblings?

____
____

Growing up, in what ways were you disciplined or punished by your parents?

____
____

Please describe your home atmosphere while growing up:

____
____
____
____

Did you experience any significant disruptions while growing up (e.g., prolonged separation from one or both parents, significant geographical move)?

____
____

If you have a step-parent, please give your age at the time the marriage took place:

____

Has anyone (parents, relatives, and/or friends) ever interfered with your life (e.g., marriage, occupation, etc.)?

____
____

How far did you go in school?

______ did not attend high school
______ some high school
______ completed high school
______ some college/university
______ completed college/university
______ some graduate school
______ completed graduate degree

Current Occupation: ____
How long have you been working at your current job? ___________________________________

Does your present work satisfy you? ______ Please explain:

____
____

If you are not currently working, please indicate the reason:

____
____

What kinds of jobs have you had in the past?

____

____

Have you had had difficulty keeping long-term jobs? (If yes, please describe.)

____

____

Have you ever been in the military? If yes, please indicate when and which branch.

____

____

Current Relationships: What is your current relationship status? (Please check all that apply.)

______ Single
______ In a long-term relationship
______ Married (Date: ___________)
______ Cohabitating (Date: ___________)
______ Separated (Date: ___________)
______ Divorced (Date: ___________)
______ Widowed (Date: ___________)

If married, cohabitating, or in a long-term relationship, what is your partner's age? ____
How long have you been living with/married to your partner? ______
How long have you known each other? ______
What is the last grade completed by your partner or highest degree? ______
What is your partner's current occupation? ____

What words best describe your partner's personality?

____

____

____

In what areas are you compatible?

____

____

____

In what areas are you incompatible (e.g., sources of conflict)?

____

____

____

Please rate your overall level of satisfaction with the relationship. Select a number from 0 to 10, where 0 means very dissatisfied, 5 means neutral, and 10 means very satisfied. Rating: ______

Children: How many children do you have? ______ How many stepchildren? ______
Please give their names, genders, and ages:

____

____

Do any of your children present special problems?

____

____

Any relevant information regarding abortions or miscarriages?

____

____

Finances: Annual family income:

______ less than $19,999 ______ $60,000 - 79,999
______ $20,000 - 39,999 ______ $80,000 - 99,999
______ $ 40,000 - 59,999 ______ more than $100,000

Number of people supported by family income (including self): ______
Does your current family income feel adequate for your needs? If no, please explain:

____

____

Legal: Do you currently have, or have you had in the past, any legal difficulties (other than for minor traffic violations)? If yes, please explain:

____

____

Religion: What was your religious background growing up? ______________________
______ Practicing ______ Non-practicing

Current religion? _______________________ _______ Practicing ______ Non-practicing

Medical History and Current Health:

Height ______ Weight ______

Do you have a primary care doctor (internist, family doctor)? _____ Yes _____ No

If yes, please list the doctor's name and telephone number if known:

____

When was your last physical exam? Were there any abnormalities?

____

____

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

______ Heart disease
______ Cardiac arrhythmias
______ Angina or chest pain (aside from panic attacks)
______ High/low blood pressure
______ Neurological disorder (e.g., epilepsy)
______ Migraine headaches
______ Asthma
______ Other respiratory or chest disease
______ Thyroid abnormalities
______ Diabetes
______ Mitral valve prolapse
______ Vestibular or inner ear disorder
______ Contagious blood condition (e.g., hepatitis, HIV/AIDS)

If you answered yes to any of the above, please specify:

____

____

____

____

Do you have any reason to believe you might be pregnant? Yes ______ No ______

Have you ever had a concussion or head injury resulting in loss of consciousness, or which produced any symptoms following the injury? Yes ______ No ______

If yes, please specify: ____

Have you ever had any operations or surgeries? Yes ______ No ______

If yes, please specify: ____

____

Are there any medical problems that haven't been covered by above questions? If yes, please specify: ____
____
____
____

Please list any allergies you may have: ____
____
____

Please list ALL current medications (including prescriptions, birth control, over-the-counter medications, and herbal supplements), along with the reason for taking them and the dosage:

Medication: Reason: Dose:
____
____
____
____
____
____
____
____

Have you experienced any of the following in the past year (aside from during panic attacks or elevated anxiety)?

______ Convulsions
______ Frequent or chronic cough
______ Chest pain or angina pectoris
______ Spitting up blood
______ Night sweats
______ Severe shortness of breath (on exertion or at night)
______ Palpitations or irregular heartbeat
______ Swelling of hands, feet, or ankles
______ Abnormal thirst
______ Abnormal blood or urine test

If you answered yes to any of the above, please specify:
____
____
____
____

Psychiatric History

Have you suffered from other psychological problems or mental illness in the past (such as depression, alcohol or drug addiction, marriage problems, etc.)? _______ Yes ______ No

If yes, please describe your symptoms: ____

____

____

____

____

Have you been treated for these symptoms? _______ Yes ______ No

If yes, please list who treated you (name, degree, dates, contact information):

example: Charles Smith PhD (psychologist) 410-555-5555 Jan 2010 – May 2012

____

____

____

____

Have you ever received cognitive-behavioral therapy (CBT)? ____ Yes ____ No ____ Not sure

If yes (or unsure), what did you and your therapist do to work on the problem?

____

____

Have you ever been hospitalized for psychological problems? If so, please specify the nature of the hospitalization, including when and where.

____

____

Many children experience anxiety when separating from their parents (e.g., when going to school). Did you have difficulty with this as a child? ______ Yes ______ No

If yes, did it cause trouble in your life (e.g., significant distress, prevent you from doing things)?

Please specify: ____

____

____

Many children (and adults) also experience habits such as eye-blinking, nose-twitching, sniffing, throat-clearing, grunting, tapping or touching, or other "tics."

As a child, did you experience anything like this? ______ Yes ______ No

What about as an adult? ______ Yes ______ No

If yes, please specify: ____

____

____

Additional Information:

Is there any other information that we did not ask you about that would be important for us to know?