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 circle all 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, friends) ever interfered with your life (e.g., marriage, occupation, etc.)?

______________________________________________________________________________
______________________________________________________________________________

How far did you go in school?

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

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

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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?

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________