As part of your visit at the Johns Hopkins Anxiety Disorders Clinic, we ask that you complete the following 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, available only 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:  
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?

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________