

# Registration

© 010211 Norton A. Roitman, MD  
filled out by applicant, parent, guardian or completed by assistant

**Applicant** \_\_\_\_\_ age \_\_\_\_\_ sex \_\_\_\_\_ birth date \_\_\_\_\_

address \_\_\_\_\_ city, state, zip \_\_\_\_\_

phones: home \_\_\_\_\_ work \_\_\_\_\_ cell \_\_\_\_\_ email \_\_\_\_\_

best time to call at home \_\_\_\_\_ work \_\_\_\_\_ days off (circle) Su M T W Th F S

*check your preferences:*  any contact is fine  do not call at home;  do not call at work;  do not leave messages;  do not fax

employer/school \_\_\_\_\_ job/grade \_\_\_\_\_

street address \_\_\_\_\_ city, state, zip \_\_\_\_\_

referred by \_\_\_\_\_ personal physician \_\_\_\_\_

**Primary contact** \_\_\_\_\_ relationship \_\_\_\_\_

address  check if same as above: \_\_\_\_\_ city, state, zip \_\_\_\_\_

phones: home \_\_\_\_\_ work \_\_\_\_\_ cell \_\_\_\_\_ email \_\_\_\_\_

best time to call at home \_\_\_\_\_ work \_\_\_\_\_ days off (circle) Su M T W Th F S

*check your preferences:*  any contact is fine  do not call at home;  do not call at work;  do not leave messages;  do not fax

employer/school \_\_\_\_\_ job/grade \_\_\_\_\_

street address \_\_\_\_\_ city, state, zip \_\_\_\_\_

**Secondary contact** \_\_\_\_\_ relationship \_\_\_\_\_

address  check if same as above: \_\_\_\_\_ city, state, zip \_\_\_\_\_

phones: home \_\_\_\_\_ work \_\_\_\_\_ cell \_\_\_\_\_ email \_\_\_\_\_

best time to call at home \_\_\_\_\_ work \_\_\_\_\_ days off (circle) Su M T W Th F S

*check your preferences:*  any contact is fine  do not call at home;  do not call at work;  do not leave messages;  do not fax

employer/school \_\_\_\_\_ job/grade \_\_\_\_\_

street address \_\_\_\_\_ city, state, zip \_\_\_\_\_

I request initial consultative services for myself, my family, my client and/or my dependent.

If applying for a minor, I certify that I have the legal right to obtain of consultation, evaluation and/or treatment.

Permission for services and release of information can be revoked at any time.

I understand that this initial consultation does not initiate a doctor/patient relationship and may result in a referral, report, discharge or consultation with a third party.

I understand that I am responsible for the charges incurred for these services unless a specific payor (person, third party or agency) arranged for payment in advance.

Please specify payor:  myself  \_\_\_\_\_.

Responsible party \_\_\_\_\_ date \_\_\_\_\_

Applicant \_\_\_\_\_ Age \_\_\_\_\_ Date of Evaluation \_\_\_\_\_

Filled out by  applicant  other \_\_\_\_\_ clinician \_\_\_\_\_

Please answer from the point of view of the adolescent.

Use the lines below each section or the back of the page to explain your answers. Although some questions may be difficult to answer in the space provided, do your best to be brief and to the point. During the interview you can ask questions, explain your answers, discuss whatever you like.

1. What is the purpose of your interview? Do you, or other people, think you are having any problems?

Problem list: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. When did these problems start? \_\_\_\_\_ How long do you think it will take to take care of them? \_\_\_\_\_

3. What do you think caused them? \_\_\_\_\_

Treatment

4. Did you have counseling for depression, addiction or emotional or behavioral problems?  yes  no

Table with 5 columns: Age, Where, Who treated you, What for, How long. Includes three rows of blank lines for data entry.

5. Did you take medication in the past?  yes  no (List current medications on page 4, past meds below)

Table with 6 columns: If so, What kind, What for, How much/how often, Doctor, I took it for (how long), How long ago. Includes an example row and three blank rows for data entry.

6. Were you hospitalized for these or other problems?  yes  no If so, how many times? \_\_\_\_\_

Table with 5 columns: Age, Where, Your doctor, What for (diagnosis, if any), How long. Includes three rows of blank lines for data entry.

Did you have any BAD REACTIONS to medications?  no  yes \_\_\_\_\_

Was any treatment helpful?  yes  no  sort of Explain: \_\_\_\_\_

7. Placements Other than treatment centers, list the places you lived when you did not stay with your mother and/or father.

Table with 5 columns: age, to, relative, foster/group home, shelter/detention, other. Includes five rows for listing placements.

Growing up

8. Did you have any MEDICAL problems [ ] at birth [ ] birth to age 3 [ ] 3 to 5 [ ] 5 to 12 [ ] 12 to 18? [ ] no

Please explain: (put recent and current conditions on page 4) \_\_\_\_\_

9. Did you have DELAYS or problems with: [ ] don't know

- [ ] crawling/walking [ ] coordination [ ] eating
[ ] ear infections [ ] growing [ ] weaning
[ ] learning to talk [ ] toileting [ ] attention
[ ] staying alone [ ] playing [ ] learning

10. What words fit your early PERSONALITY best: [ ] social [ ] leader [ ] loner [ ] joiner [ ] fearful [ ] temperamental [ ] self-absorbed
[ ] shy [ ] careful [ ] serious [ ] scattered [ ] fighter [ ] withdrawn [ ] impulsive [ ] aggressive [ ] thoughtless [ ] gothic [ ] stoner
[ ] rigid [ ] fearless [ ] angry [ ] fun [ ] easy going [ ] defiant [ ] weird [ ] studious [ ] other \_\_\_\_\_

11. Did you have trouble GETTING ALONG \_\_\_\_\_ [ ] no
with [ ] other kids [ ] brothers/sisters [ ] parents \_\_\_\_\_
[ ] teachers [ ] other authority figures? \_\_\_\_\_
starting in [ ] preschool [ ] KG [ ] grade \_\_\_\_\_

Any past trouble with the law? [ ] no [ ] yes \_\_\_\_\_
[ ] vandalism/theft [ ] fires [ ] drugs [ ] truant \_\_\_\_\_
[ ] hurt animals [ ] gang activity [ ] violence \_\_\_\_\_

12. Did you have WORRIES about [ ] leaving home [ ] going to school [ ] safety/heath [ ] being around people? [ ] no
When worried, did you have [ ] stomach pains [ ] trouble sleeping [ ] nightmares [ ] panic attacks? Other: \_\_\_\_\_ [ ] no

[ ] Did you ever try to harm yourself? Explain: \_\_\_\_\_ [ ] no

13. Did you undergo TRAUMA such as [ ] DEATHS, illness or losses [ ] parents DIVORCED [ ] witness ABUSE? [ ] no

Were you abused, mistreated or abandoned? [ ] yes [ ] no Explain this section below
How were you PUNISHED? [ ] not \_\_\_\_\_
[ ] timed out [ ] grounded [ ] points \_\_\_\_\_
[ ] natural consequences [ ] belted \_\_\_\_\_
[ ] lectured [ ] chores [ ] other \_\_\_\_\_

Were you [ ] poorly accepted or \_\_\_\_\_
[ ] rejected by your parents \_\_\_\_\_
[ ] raised by foster parents? \_\_\_\_\_

[ ] Did your parents lose control? \_\_\_\_\_
[ ] Did either use drugs or alcohol? \_\_\_\_\_
[ ] Were they in trouble with the law? \_\_\_\_\_

Your everyday life

14. Your school \_\_\_\_\_ [ ] none. What grade are you in? \_\_\_\_\_ What grade should you be in? \_\_\_\_\_

Learning disability [ ] no [ ] yes: [ ] reading [ ] math [ ] written language [ ] verbal [ ] receptive [ ] expressive [ ] processing [ ] speech Other \_\_\_\_\_
Special classes: [ ] none [ ] resource [ ] self-contained [ ] other: \_\_\_\_\_ Were you [ ] RPC'd [ ] Suspended [ ] Expelled [ ] Special schooled: \_\_\_\_\_

15. Do you work? Where \_\_\_\_\_ position \_\_\_\_\_ # mo/yrs at this job \_\_\_\_\_
Longest employment at \_\_\_\_\_ position \_\_\_\_\_ how long? \_\_\_\_\_

Other notable work or experience \_\_\_\_\_

16. Your educational/vocational plan \_\_\_\_\_ [ ] none Spiritual practice \_\_\_\_\_ [ ] none

17. Problems and stress. Check all areas of concern. Other \_\_\_\_\_

- [ ] PERSONAL [ ] self-control [ ] motivation [ ] concentration [ ] fatigue [ ] mood [ ] organization [ ] grief
[ ] family illness [ ] health [ ] accident [ ] adoption [ ] parenting [ ] home/household/move(s)
[ ] RELATIONSHIP [ ] friend(s) [ ] supervisor [ ] roommate [ ] coworker [ ] spouse [ ] girl/boyfriend
[ ] FAMILY [ ] fighting [ ] conflicts/divorce [ ] custody [ ] child problems [ ] parents [ ] other relatives
[ ] SCHOOL [ ] performance [ ] concentration [ ] behavioral [ ] disability [ ] accommodation
[ ] WORK [ ] conflicts [ ] fitness for duty [ ] disability [ ] financial/loss [ ] vocational direction
[ ] HABIT [ ] alcohol/drug [ ] gambling [ ] sexual [ ] obsession [ ] impulsivity [ ] other behavioral
[ ] LEGAL [ ] probation [ ] parental fitness [ ] competency [ ] drug/alcohol [ ] community safety [ ] criminal allegation
[ ] personal injury/workman compensation [ ] other \_\_\_\_\_

18. Explain how you cope with stress: \_\_\_\_\_

How well do you think you are doing? [ ] poorly [ ] could be better [ ] varies [ ] very well [ ] I feel great

19. What are your strengths and interests? [ ] reading [ ] writing [ ] music (what kind) \_\_\_\_\_ [ ] play sports (which one) \_\_\_\_\_
[ ] faith/prayer [ ] community/church [ ] building/mechanics/computer [ ] work [ ] shopping [ ] collections [ ] video/computer games [ ] play instrument
[ ] movies/TV [ ] art/photo [ ] travel [ ] friends/social [ ] blogs/chat/online [ ] gamble [ ] journal [ ] design /fashion [ ] coach/volunteer [ ] other: \_\_\_\_\_

You and your family

20. Did you go through divorce? [ ] parents divorced [ ] my divorced [ ] none Was it difficult? [ ] yes [ ] no Is it still? [ ] yes [ ] no
Are/were there problems with [ ] legal custody [ ] physical custody [ ] visitation [ ] alimony/child support [ ] parental differences [ ] abuse allegations

21. Have any of your blood relatives had EMOTIONAL, BEHAVIORAL or ADDICTION problems? [ ] yes [ ] no
[ ] addiction [ ] drugs [ ] alcohol [ ] learning disability [ ] ADHD [ ] Manic depression/bipolar [ ] depression [ ] anxiety [ ] panic [ ] autism
[ ] obsessive/compulsions [ ] psychosis/schizophrenia [ ] diagnosis unknown [ ] needed medication [ ] hospitalized [ ] other: \_\_\_\_\_

22. List your family members living in your home(s) and elsewhere. Use an "[s]" in the box to indicate step-relative.

Example SUSAN SAMPLER . age 35 . [S]mother [ ]father [ ]spouse/partner ---> [ ] Lives with you [x] other home New Jersey \_\_\_\_\_

Name \_\_\_\_\_ . age \_\_\_\_ . [ ]mother [ ]father [ ]spouse/partner ---> [ ] Lives with you [ ] other home \_\_\_\_\_

Name \_\_\_\_\_ . age \_\_\_\_ . [ ]mother [ ]father [ ]spouse/partner ---> [ ] Lives with you [ ] other home \_\_\_\_\_

Name \_\_\_\_\_ . age \_\_\_\_ . [ ]sister [ ]brother [ ]daughter [ ]son [ ]other---> [ ] Lives at home [ ] other home \_\_\_\_\_

Name \_\_\_\_\_ . age \_\_\_\_ . [ ]sister [ ]brother [ ]daughter [ ]son [ ]other---> [ ] Lives at home [ ] other home \_\_\_\_\_

Name \_\_\_\_\_ . age \_\_\_\_ . [ ]sister [ ]brother [ ]daughter [ ]son [ ]other---> [ ] Lives at home [ ] other home \_\_\_\_\_

Name \_\_\_\_\_ . age \_\_\_\_ . [ ]sister [ ]brother [ ]daughter [ ]son [ ]other---> [ ] Lives at home [ ] other home \_\_\_\_\_

Name \_\_\_\_\_ . age \_\_\_\_ . [ ]sister [ ]brother [ ]daughter [ ]son [ ]other---> [ ] Lives at home [ ] other home \_\_\_\_\_

Name \_\_\_\_\_ . age \_\_\_\_ . [ ]sister [ ]brother [ ]daughter [ ]son [ ]other---> [ ] Lives at home [ ] other home \_\_\_\_\_

**Your health**

23. Past and current MEDICAL PROBLEMS. Write in your age (approximate) when you were first diagnosed.

Medical condition(s) and/or check below \_\_\_\_\_  no medical problems  
 \_\_\_\_\_ asthma/emphysema/lung disease \_\_\_\_\_ uterus, ovaries, breast \_\_\_\_\_ polycystic ovaries \_\_\_\_\_ genital  
 \_\_\_\_\_ serious injury to arms, legs, back \_\_\_\_\_ thyroid/pituitary/hormone \_\_\_\_\_ chronic fatigue \_\_\_\_\_ Tourette's/tics  
 \_\_\_\_\_ blood pressure/anemia/valve \_\_\_\_\_ urinary/bladder \_\_\_\_\_ skin cancer/disease \_\_\_\_\_ other cancer  
 \_\_\_\_\_ ulcers/colitis/rectal/colon/esophagus \_\_\_\_\_ prostate cancer/disease \_\_\_\_\_ shaking/Parkinson's \_\_\_\_\_ AIDS/HIV/STD  
 \_\_\_\_\_ jaundice/hepatitis/liver disease \_\_\_\_\_ heart attack/heart disease \_\_\_\_\_ paralysis/sensory \_\_\_\_\_ kidney/renal  
 \_\_\_\_\_ black-outs/epilepsy/seizures \_\_\_\_\_ head injury/stroke/migraine \_\_\_\_\_ infectious disease \_\_\_\_\_ diabetes  
 \_\_\_\_\_ eyes/ears/nose/throat \_\_\_\_\_ lymphoma/leukemia/blood \_\_\_\_\_ arthritis/ lupus \_\_\_\_\_ self-injury

Other \_\_\_\_\_

24. Check any persistent or bothersome symptoms:

back problems  headaches  allergies  gastrointestinal symptoms  stomach aches  nausea  vomiting  diarrhea  
 bloody/black stools  unusual weight gain or loss  bladder control  leg swelling  excessive coughing or coughing blood  
 chest pain  wheezing  fatigue  joint pain  muscular pain  visual problems  changes in sexual functioning  sleeping  
 rash/abnormal itching  persistent fever  shortness of breath  drug problems Other \_\_\_\_\_

Last physical exam by doctor \_\_\_\_\_ Month/year \_\_\_\_\_

25. For women: Are you having monthly periods?  yes  no Using birth control?  yes  no Could you be pregnant?  yes  no

26. List below accidents or work injuries involving workman's compensation or insurance claims.

Date	Type of Injury	Location of accident	case pending?
_____	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no
_____	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no
_____	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no

27. Have you had an EKG (heart monitor)?  yes  no Was it abnormal?  yes  no

28. Ever have a head injury, an EEG (brain wave test) or seen a neurologist (brain specialist)?  yes  no

29. List the medications you are allergic to:  penicillin  sulfa  others \_\_\_\_\_

30. Do you have a poor DIET?  yes In what way? \_\_\_\_\_  no

31. CAFFEINATED beverages (energy drinks, colas, tea, coffee) each day? \_\_\_\_\_ Tobacco  chew  smoke \_\_\_\_\_

32. On average, how many cigarette packs have you smoked for how many years?  none  quit \_\_\_packs/day \_\_\_years

33. **CURRENT MEDICATIONS** and TREATMENTS you are taking still. Also list herbal remedies and supplements.

What kind	What for	How much/how often	Prescribing doctor	How long
Example: DOXYCYCLINE	acne	100 mgs/ twice a day	Dr. Smith	1 year
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**Drug and Alcohol Profile**

Check here if this section is  Not Applicable

Has anyone told you they were concerned about your drug or alcohol use?  yes  no  
 Does it annoy you when others tell you how they feel about your drinking or use?  yes  no  
 Have you ever felt guilty about drinking?  yes  no  
 Did you ever drink to get the day started when you first woke up (had an eye-opener)?  yes  no

Did you ever: have a seizure while withdrawing from alcohol or drugs?  yes  no  
 hallucinate, shake, be anxious, agitated or have physical craving after stopping?  yes  no  
 go to two or more, or switch doctors to get more prescriptions?  yes  no

Did you ever lose your memory due to alcohol or drugs?  temporarily  permanently  Ever blacked out?  
 Ever overdose  on purpose?  by accident?  go to the hospital?  stomach pumped?  admitted overnight?  
 If you no longer drink or use drugs, why did you stop? \_\_\_\_\_

Ever go to  AA  NA  CA  ACOA  Al-anon  Ever have a sponsor?  Are you familiar with the 12 steps?

**Check all the substances you have tried and circle your favorites.**

When did you start?

	Age	How much and how often do/did you use? Cost per week.	Did you stop?	When
<input checked="" type="checkbox"/> EXAMPLE (weed)	10	One or two blunts every day. \$50 to \$300 per week	<input checked="" type="checkbox"/> yes <input type="checkbox"/> no	2 months ago
<input type="checkbox"/> alcohol	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
<input type="checkbox"/> weed/marijuana	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
<input type="checkbox"/> crystal meth/speed	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
<input type="checkbox"/> cocaine/ crack	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
<input type="checkbox"/> XTC/ecstasy/MDMA/X	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
<input type="checkbox"/> heroin	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
<input type="checkbox"/> mushrooms/peyote	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
<input type="checkbox"/> LSD/ PCP	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
<input type="checkbox"/> GHB/ DXM/ K	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
<input type="checkbox"/> sherm	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
<input type="checkbox"/> Xanax/Valium/Ativan	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
<input type="checkbox"/> barbiturates	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
<input type="checkbox"/> other prescriptions	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
<input type="checkbox"/> huffing paint, glue, etc.	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
<input type="checkbox"/> other _____	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	_____
<input type="checkbox"/> I mixed them as follows _____				

Did you get into legal or other trouble in any way due to your substance use? Please explain:

List any other addiction you think you might have. \_\_\_\_\_

# Adult Psych Symptoms Checklist

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Name \_\_\_\_\_

Date \_\_\_\_\_

Filled out by \_\_\_\_\_

Relationship \_\_\_\_\_

*This questionnaire defines your problem areas. Many of these questions may not apply. Some may sound strange or be inappropriate but please do your best. You can ask questions and explain your answers during the interview.*

**Check** NOW, PAST, or N/A (Not Applicable/appropriate) for each line as it applies to you NOW, in the past only, both or neither.

For example:

**NOW PAST N/A**

Do you like to watch television?

Do you play baseball?

Do you have allergies?

Do you wet your bed?

**If you have DEPRESSION, please describe what it is like for you:** (If not, check  here, and move on to page 2)

**NOW PAST N/A**

Does your depression or sadness COME AND GO frequently?

Do your moods come OUT of the BLUE?

Is your depression triggered by things that HAPPEN?

Do you stay depressed for 2 WEEKS or more with little if any relief?

When you are depressed, do you:

**NOW PAST N/A**

... lose your ENERGY?

... have a "WHATEVER" attitude *only* when you are depressed?

... lose INTEREST in everything? ...  slow down ...  become RESTLESS?

... lose your APPETITE? ...  LOSE weight ...  GAIN weight?

Do you have trouble FALLING ASLEEP?

... wake up in the  MIDDLE of the night, or  EARLY in the morning?  wake up IN A PANIC?

... need a lot of NAP TIME?

Do you wake GASPING for breath?  SNORE?

During periods of depression, do you:

**NOW PAST N/A**

... get very ANGRY AT yourself? ...  all the time? ...  only when very depressed?

... feel GUILTY for things that are not your fault?

... STAY ALONE ...  MOPE around?

... have trouble THINKING or CONCENTRATING?

... CRY easily ...  feel DESPERATE?

If you have thoughts about hurting yourself:

**NOW PAST N/A**

Have you INJURED yourself on purpose?

Do you have THOUGHTS about taking your life?

Do you have PLANS to do it?

Have you ever TRIED to end your life?

Do you have any such thoughts or plans NOW?

# Adult Psych Symptoms Checklist

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Are you ever ON EDGE (anxiety or panic) to an extreme? (If not, check [ ] here, and move on to the next section.)

**NOW PAST N/A**

- Do your nerves effect EVERY PART of your life?
- Do you have sudden ATTACKS ...[ ] MINUTES or ... [ ] HOURS that go away quickly?
- ...do you stay nervous for a ...[ ] FEW DAYS, or ... is it [ ] ALWAYS THERE?
- Do you have FEELINGS IN YOUR BODY when you get upset, such as...
- PAINS in your ...[ ] CHEST, ...[ ] HEAD or ...[ ] STOMACH?
- When nervous, do you have trouble BREATHING?
- ... your ...[ ] HEART POUNDS? ...[ ] LOSES FEELING in your hands, head or feet?
- Do you feel SHAKY, SWEATY, FLUSHED or DIZZY when you get nervous?
- Do you AVOID PEOPLE or ...[ ] THINGS? \_\_\_\_\_
- Do you have extreme NIGHTMARES? For instance
- Do you have memories that are so real, it's like you are actually LIVING them?
- Do you ever feel OUT OF TOUCH like you are OUTSIDE OF YOUR BODY as though you are watching a movie of your life instead of living it?

Do you have abnormal MOVEMENTS of your face or other parts of your body?

(If not, check [ ] here, and move on to the next section below.)

**NOW PAST N/A**

- Do you get movements or irritations in your THROAT or MOUTH such as throat clearing or sniffing?
- Do your hands SHAKE a lot of the time?
- Do other parts of your body JERK uncontrollably?
- Does this happen only when you are nervous?
- Does it happen at BEDTIME when you are trying to fall asleep?
- Do you call out FOUL LANGUAGE out of the blue as though you have no control?
- Do you have severe HEADACHES?
- ... have you ever ...[ ] BLACKED-OUT ... [ ] have FITS ... [ ] FAINTED ... [ ] SEIZURE(S)?
- Have you WET or SOILED your clothes? ... [ ] DURING BLACKOUTS?

Do you have:

**NOW PAST N/A**

- THOUGHTS that just WON'T GO AWAY?
- ... the need to DO THINGS OVER AND OVER almost unable to stop?
- ... uncontrollable urges such as CHECKING your body, locking the door over and over again, washing, counting, or having to have everything ... [ ] "JUST SO"?
- If you try to control these, is it extremely UNCOMFORTABLE?

Do you take things very SERIOUSLY to the point that you performs:

- RITUALS, ROUTINES or HABITS that don't make sense?
- Would you or others describe you as RIGID?
- Do you ever think that "trying to be PERFECT" gets out of hand?

Do you:

**NOW PAST N/A**

- BINGE eat or PURGE food?
- Use LAXATIVES or make himself VOMIT?
- Do you think you or you are over-weight while others see you as just fine?

## Adult Psych Symptoms Checklist

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Have you done things OUT OF CHARACTER such as:

**NOWPAST N/A**

- Gone SEVERAL NIGHTS WITH LITTLE IF ANY SLEEP?
- SPENT a lot? ...  GAVE away THINGS you treasured?
- Shown a lot of ...  ENERGY? Acted exceptionally ...  STRONG or...  SMART?
- Treated OTHERS POORLY, acted RUDE, HOSTILE or ARGUMENTATIVE out of character?
- Did you feel SHAME or regret LATER about unusual things you did?
- Has your SEXUAL DRIVE or behavior ever been a concern to you?
- Do you get very, very focused on HORROR films, PAIN or REVENGE?
- Do you suffer from EXTREME JEALOUSY?
- Do these characteristics come and go together in episodes?
- Are they part of your EVERYDAY behavior?
- Do you think these out of character reactions are due only to drug use?
- Are you in one of these episodes right now?

Did you ever feel like BIZARRE things were happening, such as:

**NOW PAST N/A**

- VOICES whispering, talking, calling your name or swearing at you?
- SMELLING things no one else does?
- ... heard or saw THINGS or PEOPLE that no one else does?
- ... lost your sense of DIRECTION ...  MEMORY?
- Have you ever seen things breathing, shrinking or growing?

Have you:

**NOWPAST N/A**

- stopped TAKING CARE of yourself?
- become ill at ease WITH PEOPLE?
- ... lost your SENSE OF HUMOR?
- ... thought the RADIO or TV was TALKING to you?
- ... thought that your THOUGHTS WERE BEING READ or CONTROLLED?
- Do you have thoughts or beliefs that are IRRATIONAL or hard for others to follow, understand or believe?
- Do you think ALCOHOL or DRUGS were responsible for these reactions?

Would you use any of the following terms to describe your USUAL behavior when you were young?

- Selfish       Steals       Inattentive       Stubborn       Hurts animals
- Fidgety       Sets fires       Destructive       Anti-authority       Lacks conscience
- Lies       Fights       Restless       Distractible       Insensitive to pain
- Willful       Argues       Irresponsible       Calls out in class       Can't wait turn
- Bullies       Cheats       Disrespectful       Short attention       Acts without thinking
- Hateful       Whines       Demanding       Takes risks       Uncaring about others
- Abusive       Defiant       Out of control       Manipulative       Other:

Describe any illegal or other activities not covered elsewhere that you are concerned about below or on the back.

# Release of information

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Filled out by applicant, parent or guardian, completed by assistant.

Today's date \_\_\_\_\_

**Applicant** \_\_\_\_\_ Age \_\_\_\_ Sex \_\_\_\_ Date of Birth: \_\_\_\_\_

I hereby authorize Dr. Roitman and his staff to (check all that are applicable):

- exchange information with:
  - only request information from:
  - only release information to:

Name \_\_\_\_\_ Title \_\_\_\_\_

Street \_\_\_\_\_

City, State and Zip Code \_\_\_\_\_

Phone \_\_\_\_\_ fax \_\_\_\_\_ cell \_\_\_\_\_ **Initial** \_\_\_\_\_

Name \_\_\_\_\_ Title \_\_\_\_\_

Street \_\_\_\_\_

City, State and Zip Code \_\_\_\_\_

Phone \_\_\_\_\_ fax \_\_\_\_\_ cell \_\_\_\_\_ **Initial** \_\_\_\_\_

Name \_\_\_\_\_ Title \_\_\_\_\_

Street \_\_\_\_\_

City, State and Zip Code \_\_\_\_\_

Phone \_\_\_\_\_ fax \_\_\_\_\_ cell \_\_\_\_\_ **Initial** \_\_\_\_\_

NORTON A. ROITMAN, MD  
2340 PASEO DEL PRADO #D 307  
LAS VEGAS, NEVADA 89102

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The purpose of this release of information is to

- Coordinate treatment with other providers
- Verify attendance
- Evaluate status
- Obtain assistance
- Other \_\_\_\_\_

I release Norton A. Roitman, MD and his staff from any legal liability resulting from the release of this information with the understanding that reasonable professional safeguards will be taken. Unless otherwise specified, release authorization will expire in one year. Release of information is subject to revocation at any time.

Responsible party \_\_\_\_\_ Staff \_\_\_\_\_