PATIENT INFORMATION: **UPDATED FORM | 2020**

First Name: ____________________ MI: __________ Last Name: ____________________

Preferred: ____________________ Sex (Circle): M | F DOB: ______ / ______ / __________

Maiden: ____________________ | N/A SS#: ________ - _____ - __________

CONTACT INFORMATION: **Preferred Method of Contact (Circle): Home | Mobile | Work | Email**

Cell Phone: (________) ________ - __________ Home Phone: (________) ________ - __________

Work: (________) ________ - __________ Email: ______________________________@____________.com

Physical Address: ____ Apt/Ste: __________

City: ______________________________ State: __________

Zip: __________

If mailing address is same as physical address, please check box: ☐

Mailing Address: ____ Apt/Ste: __________

City: ______________________________ State: __________ Zip: __________

INSURANCE INFORMATION:

Primary Insurance Company Name: ____

ID#: ______________________________ Group#: ____________________ Eff. Date: ______ / ______ / __________

Insurance Co. Phone: (________) ________ - __________

Insurance Co. Address: ____ Suite: __________

City: ______________________________ State: __________ Zip: __________

(Subscriber) Self: ☐ **If other than SELF, include the primary cardholder information below.**

First Name: ____________________ MI: __________ Last Name: ____________________

Relationship: ____________________ Sex (Circle): M | F DOB: ______ / ______ / __________

Cell Phone: (________) ________ - __________ SS#: ________ - _____ - __________

Dependent Name **(EXACTLY)** as Listed on Insurance: ______________________________

Secondary Insurance Company Name: ____

ID#: ______________________________ Group#: ____________________ Eff. Date: ______ / ______ / __________

Insurance Co. Phone: (________) ________ - __________

Insurance Co. Address: ____ Suite: __________

City: ______________________________ State: __________ Zip: __________

(Subscriber) Self: ☐ **If other than SELF, include the primary cardholder information below.**

First Name: ____________________ MI: __________ Last Name: ____________________

Relationship: ____________________ Sex (Circle): M | F DOB: ______ / ______ / __________

Cell Phone: (________) ________ - __________ SS#: ________ - _____ - __________

Dependent Name **(EXACTLY)** as Listed on Insurance: ______________________________

NEXT OF KIN | SECONDARY CONTACT INFORMATION:

Name: ____ Relationship: ____________________

Phone: (________) ________ - __________ Email: ______________________________@____________.com

Address: ____ Apt/Ste: __________

City: ______________________________ State: __________ Zip: __________

PHARMACY INFORMATION:

Pharmacy Name: ______________________________ Phone: (________) ________ - __________

Address: ____ Ste: __________

City: ______________________________ State: __________ Zip: __________

PROVIDE A VALID FORM OF PHOTO ID & CURRENT INSURANCE CARDS FOR 2019 CHART UPDATE

MEDICATION LIST

Patient Name: ____ **Date:** ______________________

	Name of Medication	Dosage	Frequency	Prescribed By
1.	______________________	______ mg/g	__________________	______________
2.	______________________	______ mg/g	__________________	______________
3.	______________________	______ mg/g	__________________	______________
4.	______________________	______ mg/g	__________________	______________
5.	______________________	______ mg/g	__________________	______________
6.	______________________	______ mg/g	__________________	______________
7.	______________________	______ mg/g	__________________	______________
8.	______________________	______ mg/g	__________________	______________
9.	______________________	______ mg/g	__________________	______________
10.	______________________	______ mg/g	__________________	______________
11.	______________________	______ mg/g	__________________	______________
12.	______________________	______ mg/g	__________________	______________
13.	______________________	______ mg/g	__________________	______________
14.	______________________	______ mg/g	__________________	______________
15.	______________________	______ mg/g	__________________	______________
16.	______________________	______ mg/g	__________________	______________
17.	______________________	______ mg/g	__________________	______________
18.	______________________	______ mg/g	__________________	______________
19.	______________________	______ mg/g	__________________	______________
20.	______________________	______ mg/g	__________________	______________
21.	______________________	______ mg/g	__________________	______________
22.	______________________	______ mg/g	__________________	______________
23.	______________________	______ mg/g	__________________	______________
24.	______________________	______ mg/g	__________________	______________
25.	______________________	______ mg/g	__________________	______________

ANY ADDITIONAL INFORMATION YOU WANT US TO KNOW:

____
____
____
____
____

NOTES (Dr. Bishop's OFFICE staff ONLY: *Information Entered:* *Date:* ____________ *By:* ______________________

____
____
____
____
____
____
____

PATIENT'S RIGHTS AND RESPONSIBILITIES:

Dr. Bishop and his staff will make our best efforts to assure your rights, as listed below:

- Considerate, respectful care
- Personal and informational privacy
- Access to your medical records, as described in the HIPAA regulations and the MS State Board of Medical Licensure
- Participation in the treatment planning process
- Explanation of need to transfer to another treatment setting, e.g., hospital admission, partial hospital or intensive outpatient, mental health care, another physician.
- Have information communicated in understandable terms
- Informed consent about your treatment

YOUR RESPONSIBILITIES:

- Provide complete and accurate information about your symptoms, treatment, medical conditions, complications, treatment by other physicians and/or counselors, and social/legal occupational situations that may be germane to your diagnosis/treatment.
- Actively participate in and completely with your agreed-upon treatment plan, including maintenance of: appointments, therapy, referrals, prescriptions, medication treatment, completion of rating scales, as well as the overall examination and treatment process.
- Fulfill your financial obligations for treatment in a timely manner.
- Be respectful and courteous to physician, staff, and other patients.
- Be respectful of office property.
- Utilize the complaint resolution process, as outlined in information for patients to resolve conflicts occurring within the practice.

I have read and understand the above information. I have been given the opportunity to ask questions and have any part I do not understand explained to me. I realize that this agreement is binding upon my treatment contract and any breach by either party will be viewed as a unilateral termination of the treatment contract.

Patient Signature: ____ Date: ______________

PAYMENT POLICY:

I understand that Dr. Bishop does not "carry accounts". I understand that I am responsible for services rendered, with payment due in full at the time of delivery of services unless prior arrangements have been made with the consent of both parties. I understand that my insurance may pay only party of my visit and I am responsible for copayments, deductibles, or services disallowed for such issues as pre-existing illness.

I understand that unless Dr. Bishop has a PPO arrangement with my insurance company; all insurance issues are between my insurance company and me; and have no bearing on my responsibility for full payment of all services.

I understand that if I request or require a service not covered by my insurance carrier and if I have been advised in advance that the insurance is not likely to cover the service then I am responsible for payment for that service prior to being.

I understand that Dr. Bishop may utilize a collection agency or attorney and avail himself of all applicable state laws to come tell payment of unpaid balances. In such a case, I (the debtor) will be responsible for the payment of any and all fees associated with the selection process, as well as any interest at the state allowed rate on the accrued balance.

Patient Signature: ____ Date: ______________

URINE DRUG SCREEN POLICY:

I understand that if Dr. Bishop prescribes a controlled medication, i.e., a benzodiazepine (Xanax, Klonopin, Valium, Ativan), sedative/sleep medication (Ambien), or stimulant (amphetamine, methylphenidate, dextroamphetamine, lisdexamfetamine, dimesylate), I will be required to submit (at minimum) 3 urine drugs screens each calendar year. I fully understand that I will be responsible for the cost of the urine drug screen. The fee for a urine drug screen in the clinic is $30 and will be due at the time of the office visit. **The urine drug screen (80305 billing code) is generally considered medically unnecessary and is performed solely for the purpose of complying with a 3rd-party (MS State Medical Board) mandate as a condition of this physician prescribing controlled medication to you.**

Patient Signature: ____ Date: ______________

NOTICE OF PRIVACY POLICIES:

- With my consent, Dr. Bishop may use and disclose protected health insurance about me to carry out treatment, payment, and healthcare operations.

CONSENT GIVEN: Yes | No CONSENT DECLINED: Yes | No

- I may request a complete copy of such uses and disclosures prior to signing this consent. Dr. Bishop reserves the right to revise the Notice of Privacy Practices at any times, which may be obtained by forwarding a written request to the above address.
- With my consent, Dr. Bishop may call my home or other designated locations and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out treatment, payment, and healthcare operations, i.e., such as appointment reminders, insurance items, and calls pertaining to my clinical care.

CONSENT GIVEN: Yes | No CONSENT DECLINED: Yes | No

- With my consent, Dr. Bishop may mail to my home or other designated locations any items to assist the practice with treatment, payment, healthcare operations, appointment reminders, patient statements.

CONSENT GIVEN: Yes | No CONSENT DECLINED: Yes | No

- I have the right to request Dr. Bishop restrict how my protected health information is used/disclosed to carry out treatment/payment/healthcare operations. However, Dr. Bishop is not required to agree to the request of restriction, but if he does, it is bound by this agreement.
- By signing this agreement, I am consenting for Dr. Bishop to use and disclose my protected health information to carry out treatment, payment, and healthcare operations; and acknowledge the receipt of the Notice of Privacy Policies.
- I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.
- Evaluation and treatment may be contingent upon my consent.

Patient/Legal Guardian Signature: _________________________ Patient Printed Name: _________________________

Patient/Legal Guardian Name: ____________________________ Date: __________________________

MEDICATION REFILL POLICY:

- It is our policy to prescribe enough medication and refills to last until the next appointment, which is made at the time of checkout. If a patient cancels a follow-up visit and subsequently runs out of medication, our office will only give new prescriptions at the time of the in-office (face-to-face) visit with Dr. Bishop.

- It is patient's responsibility to remain current with their appointment schedule in order to receive medically necessary evaluation and monitoring prior to initiating, maintaining, or altering a medication regimen. To minimize errors and maintain patient safety, the practice will not call in, fax, or mail any medication refills in between scheduled appointments.

- If you have an emergency situation and must obtain a medication refill before your next appointment, our policy requires a call from the pharmacy. If dr. Bishop approves the partial refill, our clinic will either call or fax the pharmacy on file. This will only be filled enough to cover the patient until the next scheduled follow up appointment. We expect to have a standing appointment in the near future before providing medication refills. Please note, all partial refills are for emergency situations only. If a patient fails to keep an appointment after their prescription runs out, it is the patient's responsibility to schedule an appointment before any new medication prescriptions will be dispensed.

- We do not prescribe stimulants, benzodiazepines, and other controlled medications without evaluating the patient in the office. We will need a police report if you ask for a medication refill request for controlled medication due to a theft. If the medication has been damaged in any way and needs to be replaced, we require ALL damaged medication to be returned to our practice for pill count verification and proper disposal.

- Our clinician reserves the right to refuse refilling any medication if they believe it is clinically necessary to evaluate the patient before prescribing medication. Dr. Bishop does not accept faxed refill requests for medications that have zero refills. Per our clinic policy, all patients should be seen in the clinic for their follow-up appointment to receive any continuation or new medication. Our clinic will only accept medication prior authorizations via CoverMyMeds.

- Patient Note: Do not fill prescriptions from the practice anywhere except your pharmacy, i.e, the pharmacy listed in your chart. If you fill a prescription at a different pharmacy, also please be aware that any controlled substance prescriptions (per state law) cannot be transferred to a different pharmacy. If you fill a prescription at a pharmacy other than your home pharmacy and a problem arises, we will not write a new prescription or call in a prescription to your home pharmacy. It is the patient's responsibility to discuss the issues with the pharmacy, as there is nothing our practice can do if the proper prescription fill steps were not taken beforehand. This clinic will not call in, transfer, or write new prescriptions. A follow up appointment must take place with the duration frequency discussed at last visit.

Patient Signature: ____ Date: ______________

FINANCIAL POLICY:

- **Form Fees:** (Based on length, complexity, medical decision making) **Minimum fee of $50.00** and escalates in 1/6-hour increments of an additional $50.00.
- **Registration:** All patients must complete our patient information form. If changes occur, patients should inform the office immediately. **We must have a current photo ID and insurance card on file.**
- **Phone Management Fee:** $50.00 fee for managing treating any minor problems not requiring an office visit or person-to-person contact with the physician. **All phone management fees will be due at the time of the call and billed to the credit card on file.**
- **Missed Appointments/Late Cancellations:** As of July 1, 2020, all missed appointments/late cancellations **under 24 hours (1 business day) will receive a fee of $40.00 that will be billed to the credit card on file. There will be no exceptions.**
- **Prior Authorization Fee:** $25.00 (for any medication prior authorization forms that are filled out/submitted to insurance/pharmacy by provider and/or staff **through CoverMyMeds only**)
- Insurance: We accept Medicare(No Advantage Plans), Medicaid, Molina, Blue Cross and Blue Shield, United Healthcare. If we are not in network with your insurance company, you will be a patient pay and will be responsible for the entirety of your visit.
- Examples of Self-Pay Patients: Ambetter, Aetna, BCBS-Comcast, BCBS-Nissan (Magellan/Beacon Health), CHIP, Cigna, Fox Everett, Healthsmart Benefits, Humana (Commercial, Golden Rule, Medicare), ALL Medicare Advantage Plans, MS Health Partners, TriCare, TriWest, WellCare, Worker's Compensation.

REQUIRED INFORMATION BELOW

Credit or Debit Card Information: Name: ____

Card Number: ___________-___________-___________-___________

Expiration Date: __________/__________

CSV: ___________

Billing Zip Code: ____________

Thank you for understanding and complying with our office policies. Please let us know if you have any questions or concerns.

Patient Printed Name: ____________________________________ Date: _____________

Patient Signature: ____________________________________ Date: _____________

Updated May 21, 2021

INTAKE HISTORY: Name: ______________________ DOB: ____/____/_____ Age: ________

Referral Source: (circle appropriate): Self | Friend | Relative | Dr. ______________ | Other: ______________

For what reason are you seeking the services of Dr. Bishop? ______________________________

MEDICAL HISTORY:

Medication Allergies: ______________________________ | None

Surgeries/Complications: ______________________________

Medical Illnesses/Complications: ______________________________

Current Medications (dosage and frequency): ______________________________

Do or have you taken steroids? Yes | No______________ Do you take hormones? Yes | No ______________

Do you or have you used in the last year?

Alcohol: Yes | No (Amount________/Frequency________)

Cocaine: Yes | No (Amount________/Frequency________)

Amphetamine/Speed: Yes | No (Amount________/Frequency________)

Ecstasy/Club Drugs: Yes | No (Amount________/Frequency________)

Marijuana: Yes | No (Amount________/Frequency________)

Pain pills: Yes | No (Recreation/Overtaking)

Tobacco: Yes | No (Type________/Daily Amount________)

Xanax/Klonopin: Yes | No (Amount________/Frequency________)

Current weight: __________ Height: __________ Recent change in weight: ______________________

Exercise (type, frequency, intensity): ______________________________

REVIEW OF SYSTEMS: **(Circle the symptoms that currently apply to you)**

- Headaches
- Blurred vision
- Double vision
- Decreased vision
- Dizziness
- Ringing in the ears
- Decreased hearing
- Chest pain
- Rapid heartbeat
- Shortness of breath
- Wheezing
- Diarrhea
- Nausea
- Vomiting
- Abdominal pain
- Frequent urination
- Pain on urination
- Urinary hesitation
- Urinary incontinence
- Decreased sexual ability
- Muscle pain
- Joint pain
- Weakness
- Unsteady gait
- Tremor
- Slowed muscle movement
- Slurred speech

Other: ______________________________

SOCIAL HISTORY: **(Please account for each designated period of your life, as indicated below)**

Birth to 1st grade:

- In what city did you live?
- Were your mother and father both in the household? (Yes | No) If not, why?
- Did you have siblings in the household? (Yes | No)
- Did you have step-or half-siblings in the household? (Yes | No)
- Did you have a stepparent in the household? (Yes | No)
- If the above did not apply, what was your situation?
- How would you describe the mood of your early childhood?

First grade through 6th grade:

- In what city did you live?
- Were your mother and father both in the household? (Yes | No) If not, why?
- Did you have siblings in the household? (Yes | No)
- Did you have step-or half-siblings in the household? (Yes | No)
- Did you have a stepparent in the household? (Yes | No)
- If the above did not apply, what was your situation?
- What was your general grade performance?
- Did you require special education services? (Yes | No)
- Did you fail any grades? (Yes | No)
- Were you in advance classes? (Yes | No)
- What were your best subjects?
- What were your worst subjects?
- Receive discipline, e.g., in school suspension, expulsion? (Yes | No)
- Did you take medications for behavior or ADD? (Yes | No)
- Did you have many friends? (Yes | No)
- Did you participate in sports, scouts, etc.? (Yes | No)
- Did you attend church? (Yes | No)

Junior high through 12th grade:

- In what city did you live?
- Were your mother and father both in the household? (Yes | No) If not, why?
- Did you have siblings in the household? (Yes | No)
- Did you have step-or half-siblings in the household? (Yes | No)
- Did you have a stepparent in the household? (Yes | No)
- If the above did not apply, what was your situation?
- What was your general grade performance?
- Did you require special education services? (Yes | No)
- Did you fail any grades? (Yes | No)
- Were you in advance classes? (Yes | No)
- What were your best subjects?
- What were your worst subjects?
- Receive discipline, e.g., in school suspension, expulsion? (Yes | No)
- Did you take medications for behavior or ADD? (Yes | No)
- Did you have many friends? (Yes | No)
- Did you participate in extracurricular activities? (Yes | No)
- Did you attend church? (Yes | No)
- Did you have any legal issues? (Yes | No) If so, what?
- What did you do for fun?
- Did you date? (Yes | No)
- Did you have any serious relationships? (Yes | No)
- Did you use drugs or alcohol? (Yes | No)
- Did you use tobacco? (Yes | No)

College through graduate/professional school:

- Where did you attend?
- What was your general grade performance?
- How diligent were your grades?
- Did you to a fraternity/sorority? (Yes | No)
- What were your favorite subjects?
- What were your least favorite subjects?
- What was your major?
- Did you have many friends? (Yes | No)
- Did you participate in extracurricular activities ? (Yes | No)
- Did you attend church? (Yes | No)
- Did you date? (Yes | No)
- Did you have any serious relationships? (Yes | No)

- Did you use drugs or alcohol? (Yes | No)

SOCIAL HISTORY (Continued):

Employment History:

	Date	Job/Position	Reason for Leaving
1.	___________	____________________	____
2.	___________	____________________	____
3.	___________	____________________	____
4.	___________	____________________	____
5.	___________	____________________	____
6.	___________	____________________	____

FAMILY HISTORY:

Father:

Living (age): ________ Deceased (age): ________ Occupation: ________________ Medical illnesses: ________________________________

Psychiatric illnesses: ________________________ Education: ________ In household during your youth? (Yes | No) If no, explain:________

____

Briefly, describe your father's personality and your relationship with him: ____

____

____

____

Mother:

Living (age): ________ Deceased (age): ________ Occupation: ________________ Medical illnesses: ________________________________

Psychiatric illnesses: ________________________ Education: ________ In household during your youth? (Yes | No) If no, explain:________

____

Briefly, describe your mother's personality and your relationship with her: ____

____

____

____

Siblings (Brothers):

1. Age: ________ Occupation: ______________________ Psychiatric illnesses: ________________________________
   Personality traits: ____
   Relationship with you: ____
2. Age: ________ Occupation: ______________________ Psychiatric illnesses: ________________________________
   Personality traits: ____
   Relationship with you: ____
3. Age: ________ Occupation: ______________________ Psychiatric illnesses: ________________________________
   Personality traits: ____
   Relationship with you: ____

Siblings (Sisters):

1. Age: ________ Occupation: ______________________ Psychiatric illnesses: ________________________________
   Personality traits: ____
   Relationship with you: ____
2. Age: ________ Occupation: ______________________ Psychiatric illnesses: ________________________________
   Personality traits: ____
   Relationship with you: ____
3. Age: ________ Occupation: ______________________ Psychiatric illnesses: ________________________________
   Personality traits: ____
   Relationship with you: ____

Please list any other "blood relatives" that have or that you suspect have mental pathology: ________________________________

____

____

Marriage and Children: (Please list marriages and children below)

1. ____
   ____
2. ____
   ____
3. ____
   ____
4. ____
   ____

Sleep History: Bedtime: __________ How long does it take you to fall asleep: ___________Number of awakenings/frequency: __________

Time out of bed: __________________ Do you feel rested on awakening: (Yes | No) Do you snore: (Yes | No) Restless legs? (Yes | No)

Stop breathing in sleep? (Yes | No) Other:____

PSYCHOTROPIC MEDICATION HISTORY:
Below is a list of common psychotropic medications. Please circle all medications you have taken. In the space provided, indicate your response, when the medication was taken and for what duration (if known).

Prozac (fluoxetine), Paxil (paroxetine), Zoloft (sertraline), Celexa (citalopram), Lexapro, LuVox (fluvoxamine), Anafranil: ______________

Wellbutrin (bupropion), Remeron (mirtazapine), Desyrel (trazodone), Effexor (venlafaxine), Cymbalta: ______________

Ativan (lorazepam), Xanax (alprazolam), Tranxene (cholorazepate), Klonopin (clonazepam), Librium, Valium: ______________

Risperdal, Zyprexa, Geodon, Seroquel, Abilify, Saphris, Haldon, Navane, Trilafon, Stelazine, Prolixin, Clozaril, Thorazine: ______________

Lithium, Tegretol, Depakote, Trileptal, Topamax, Neurontin, Lyrica, Gabatril, Zonegran, Dilantin, phenobarbital: ______________

Ambien, Lunesta, Sonata, Restoril, Halcion, Dalmane: ______________

Adderall, Vyvanse, Ritalin, Concerta, Focalin, Dexedrine: ______________

Strattera, clonidine, Tenex, Intuniv: ______________

Other: ______________

PAST PSYCHIATRIC HISTORY:
Outpatient Treatment: (Please list all previous treating physicians and/or therapists; and dates, nature, duration, and focus of treatment)

Inpatient Treatment: (Please list all previous treating physicians and/or therapists; and the dates, nature, duration, and treatment results)

Reason for Treatment: (Briefly state below the areas of concern, for which you are seeking treatment)

SYMPTOM QUESTIONNAIRE: Name: ___________________________ Date: _________________

Please answer the following questions as you experienced since your last visit. If this is your 1st visit, answer as to how you have been experiencing these since your symptom onset. Please us the following rating.

0 = Not present	1 = Very infrequent	2 = Infrequent	3 = Frequent	4 = Very Frequent

	1.	Manage day-to-day life. (Getting places on time, handling money, making decisions)
	2.	Household responsibility. (Shopping, cooking, laundry, cleaning)
	3.	Work. (Click completing tasks, performance, completing assignments, attendance)
	4.	School. (Academic performance, completing assignments, attendance)
	5.	Leisure time or recreational activities.
	6.	Adjusting to major life stresses. (Separation, job, divorce, new job, a death, moving)
	7.	Relationships with family members.
	8.	Getting along with others outside of your family.
	9.	Isolation or feelings of loneliness.
	10	Being able to feel close to others.
	11	Developing independence.
	12	Goals or direction in life.
	13	Lack of self-confidence, feeling bad about yourself.
	14	Apathy, lack of interest in things.
	15	Depression, hopelessness.
	16	Suicidal thoughts or behavior.
	17	Homicidal thoughts or behavior.
	18	Physical symptoms. (Headaches, pains, sleep, appetite)
	19	Fear, anxiety, panic.
	20	Confusion, concentration, memory.
	21	Disturbing thoughts or beliefs.
	22	Manic or bizarre behavior.
	23	Mood swings, unstable moods.
	24	Uncontrollable compulsive behavior.
	25	Drinking alcohol or illegal drug use.
	26	Controlling temper, outbursts of anger, violence.
	27	Impulsive, illegal, or reckless behavior.
	27	Feeling satisfaction in your life.
	28	Sexual activities or preoccupation.
	30	Hearing voices, seeing things.
	31	Being realistic about yourself and others.
	32	Recognizing and expressing emotions appropriately.

SCL-90:

Listed below are a number of thoughts, feelings, and behaviors. Please evaluate each item according to its presence over the last few weeks or since your symptoms have occurred. Please us the following rating.

0 = **NO** difficulty	1 = a **LITTLE** bit of difficulty	2 = **MODERATE** difficulty	3 = **QUITE** a **BIT** of difficulty	4 = **EXTREME** difficulty

1.	Headaches.	0	1	2	3	4
2.	Faintness or dizziness.	0	1	2	3	4
3.	Pains in heart or chest.	0	1	2	3	4
4.	Pains in lower back.	0	1	2	3	4
5.	Nausea or upset stomach.	0	1	2	3	4
6.	Soreness of your muscles.	0	1	2	3	4
7.	Trouble getting your breath.	0	1	2	3	4
8.	Hot or cold spells.	0	1	2	3	4
9.	Numbness or tingling in parts of your body.	0	1	2	3	4
10.	A lump in your throat.	0	1	2	3	4

SCL-90 (Continued):

11.	Feeling weak in parts of your body.	0	1	2	3	4
12.	Heavy feelings in your arms or legs.	0	1	2	3	4
13.	Repeated, unpleasant thoughts that will not leave your mind.	0	1	2	3	4
14.	Trouble remembering things.	0	1	2	3	4
15.	Worried about sloppiness or carelessness.	0	1	2	3	4
16.	Feeling blocked in getting things done.	0	1	2	3	4
17.	Having to do things very slowly to ensure correctness.	0	1	2	3	4
18.	Having to check and double check what you do.	0	1	2	3	4
19.	Difficulty making decisions.	0	1	2	3	4
20.	Your mind going blank.	0	1	2	3	4
21.	Trouble concentrating.	0	1	2	3	4
22.	Having to repeat the same actions such as touching, counting, washing.	0	1	2	3	4
23.	Feeling critical of others.	0	1	2	3	4
24.	Feeling shy or uneasy with the opposite sex.	0	1	2	3	4
25.	Your feelings being easily hurt.	0	1	2	3	4
26.	Feeling others do not understand you or are unsympathetic.	0	1	2	3	4
27.	Feeling that people are unfriendly or dislike you.	0	1	2	3	4
28.	Feeling inferior to others.	0	1	2	3	4
29.	Feeling uneasy when people are watching you or talking about you.	0	1	2	3	4
30.	Feeling very self-conscious with others.	0	1	2	3	4
31.	Feeling uncomfortable about eating or drinking in public.	0	1	2	3	4
32.	Loss of sexual interest or pleasure.	0	1	2	3	4
33.	Feeling low in energy or slow down.	0	1	2	3	4
34.	Thoughts of ending your life.	0	1	2	3	4
35.	Crying easily.	0	1	2	3	4
36.	Feeling of being caught or trapped.	0	1	2	3	4
37.	Blaming yourself for things.	0	1	2	3	4
38.	Feeling lonely.	0	1	2	3	4
39.	Feeling blue.	0	1	2	3	4
40.	Worrying too much about things.	0	1	2	3	4
41.	Feeling no interest in things.	0	1	2	3	4
42.	Feeling hopeless about the future.	0	1	2	3	4
43.	Feeling everything is an effort.	0	1	2	3	4
44.	Feeling of worthlessness.	0	1	2	3	4
45.	Nervous or shakiness inside.	0	1	2	3	4
46.	Trembling.	0	1	2	3	4
47.	Suddenly scared for no reason.	0	1	2	3	4
48.	Feeling fearful.	0	1	2	3	4
49.	Heart pounding or racing.	0	1	2	3	4
50.	Feeling tense or keyed up.	0	1	2	3	4
51.	Spells of terror or panic.	0	1	2	3	4
52.	Feeling so restless you could not sit still.	0	1	2	3	4
53.	The feeling that something bad is going to happen to you.	0	1	2	3	4
54.	Thoughts and images of a frightening nature.	0	1	2	3	4
55.	Feeling easily annoyed or irritated.	0	1	2	3	4
56.	Temper outbursts that you could not control.	0	1	2	3	4
57.	Having urges to beat, injure, or harm someone.	0	1	2	3	4
58.	Having urges to break or smash things.	0	1	2	3	4
59.	Getting into frequent arguments.	0	1	2	3	4
60.	Shouting or throwing things.	0	1	2	3	4
61.	Feeling afraid in open spaces or in the streets.	0	1	2	3	4
62.	Feeling afraid to go out of your house alone.	0	1	2	3	4
63.	Feeling afraid to travel on buses, subways, trains, or planes.	0	1	2	3	4
64.	Having to avoid certain things, places, or activities because they frighten you.	0	1	2	3	4
65.	Feeling uneasy in crowds, such as shopping or at a movie.	0	1	2	3	4
66.	Feeling nervous when you are left alone.	0	1	2	3	4
67.	Feeling you will faint in public.	0	1	2	3	4
68.	Feeling others are to blame for most of your troubles.	0	1	2	3	4
69.	Feeling that most people cannot be trusted.	0	1	2	3	4
70.	Feeling that you are watched or talked about by others.	0	1	2	3	4

SCL-90 (Continued):

71.	Having ideas or believes that others do not share.	0	1	2	3	4
72.	Others not giving you proper credit for your achievements.	0	1	2	3	4
73.	Feeling that people will take advantage of you if you let them.	0	1	2	3	4
74.	The idea that someone else can control your thoughts.	0	1	2	3	4
75.	Hearing voices that other people do not hear.	0	1	2	3	4
76.	Other people being aware of your private thoughts.	0	1	2	3	4
77.	Having thoughts that are not your own.	0	1	2	3	4
78.	Feeling lonely even when you are with people.	0	1	2	3	4
79.	Having thoughts about sex that bother you a lot.	0	1	2	3	4
80.	The idea that you should be punished for your sins.	0	1	2	3	4
81.	The idea that something is seriously wrong with your body.	0	1	2	3	4
82.	Never feeling close to another person.	0	1	2	3	4
83.	The idea that something is wrong with your mind.	0	1	2	3	4
84.	Poor appetite.	0	1	2	3	4
85.	Overeating.	0	1	2	3	4
86.	Trouble falling asleep.	0	1	2	3	4
87.	Awakening in the early morning.	0	1	2	3	4
88.	Sleep that is restless or disturbed.	0	1	2	3	4
89.	Thoughts of death or dying.	0	1	2	3	4
90.	Feelings of guilt.	0	1	2	3	4

PERSONALITY QUESTIONNAIRE:

Introduction:

This is a personality test; it will help you understand why you act the way that you do, and how your personality is structured. Please follow the instructions below.

Instructions:

In the table below (for each statement, 1-50), mark in the box to the left of the statement how much you agree with on the below-listed scale.

1 = Disagree	2 = Slightly Disagree	3 = Neutral	4 = Slightly Agree	5 = Agree

Test:

Rating	I…		Rating	I…	
	1.	Am the life of the party.		26	Have little to say.
	2.	Feel little concern for others.		27	Have a soft heart.
	3.	Am always prepared.		27	Often forget to put things back in their proper place.
	4.	Get stressed out easily.		28	Get upset easily.
	5.	Have a rich vocabulary.		30	Do not have a good imagination.
	6.	Do not talk a lot.		31	Talk to many different people at parties.
	7.	Am interested in people.		32	Am not really interested in others.
	8.	Leave my belongings around.		33	Like order.
	9.	Am relaxed most of the time.		34	Change my mood a lot.
	10	Have difficulty understanding abstract ideas.		35	Am quick to understand things.
	11	Feel uncomfortable around people.		36	Do not like to draw attention to myself.
	12	Insult people.		37	Take time out for others.
	13	Pay attention to details.		38	Shirk (avoid) my duties.
	14	Worry about things.		39	Have frequent mood swings.
	15	Have a vivid imagination.		40.	Use difficult words.
	16.	Keep in the background.		41.	Do not mind being the center of attention.
	17.	Sympathize with others' feelings.		42.	Feel others' emotions.
	18.	Make a mess of things.		43.	Follow a schedule.
	19.	Seldom feel blue.		44.	Get irritated easily.
	20.	Am not interested in abstract ideas.		45.	Spend time reflecting on things.
	21.	Start conversations.		46.	Am quiet around strangers.
	22.	Am not interested in other people's problems.		47.	Make people feel at ease.
	23.	Get chores done right away.		48.	Am exciting in my work.
	24.	Am easily disturbed.		49.	Often feel blue.
	25.	Have excellent ideas.		50.	Am full of ideas.