Harmony Satre, PsyD

Licensed Psychologist, PSY22871

4000 Broadway, Suite 4 Oakland CA 94611 | Phone: 510.402.5341 Fax: 510.288.0444

PARTICIPANT CLINICAL INTERVIEW

Participant Name: ________________________________ **Date:** ____________

Address: ____

Phone: (Home) ____________________ (Cell) ____________________

Birth Date: ______________ Age: ________ Sex: ________ Dominant Hand: ____________

Birth Place: ____

Marital Status: ______________ Occupation: ______________________________

Race: ____________________ Ethnic Identity: ____________________

Primary Language: ____________________ Secondary Language: ____________________

Physical Disabilities: ____

Current Living situation: ____

MILITARY HISTORY

Branch ____________________ From ________ to ________ Highest Rank Achieved ____________

Duties ____

Branch ____________________ From ________ to ________ Highest Rank Achieved ____________

Duties ____

FAMILY HISTORY

Answer the following questions with regard to your **biological** parents and siblings.

Mother

Education: ____________________ Occupation: ____________________

Learning Disorders: ____No ____Yes - Describe: ______________________________

Health history: ____

Mental health history: ____

Father

Education: ____________________ Occupation: ____________________

Learning Disorders: ____No ____Yes - Describe: ______________________________

Health history: ____

Mental health history: ____

Siblings

How many brothers and sisters do you have? _______ Brothers _______Sisters Your - birth order? ____________

Do any of your brothers or sisters have physical, academic, or psychological problems? ____ No ____ Yes

Describe: ____

Who raised you (check all relevant answers):

____ Biological parents ____ First degree relatives ____ Foster parents

____ Biological & step parents ____ Adoptive parents ____ Institutional setting

____ Others - Who? ____

Please check any of the following characteristics close biological family members had, and describe problem:

Condition	Person and type/severity	Condition	Person and type/severity
____ Epilepsy/seizures	____________	____ Parkinson's disease	____________
____ Learning disability	____________	____ Other neurological disease	____________
____ Left-handedness	____________	____ Alcoholism	____________
____ Mental retardation	____________	____ Drug abuse of any kind	____________
____ Alzheimer's disease	____________	____ Manic-depression (bipolar)	____________
____ Huntington's disease	____________	____ Depression	____________
____ Multiple sclerosis	____________	____ Personality disorder	____________

NAME____

___ Schizophrenia ______________________
___ Other psychiatric disorder ______________________
___ Speech or language disorder______________________
___ Other major disease ______________________

BIRTH DETAILS

On the following chart, please mark if any of the following apply for the period of time FROM YOUR CONCEPTION TO DELIVERY, and if so, how often. If you wish to add anything or make comments, please do so below the chart or in the comments section at the end of the questionnaire. (Please note that not everything on this list is a problem)

Did your mother use/experience/ participate in ...	Never	1 to 3 times during conception or pregnancy	More than 3 times, but not with any regularity (such as once per month)*	Fairly Often	Almost Always	Always	Don't Know
Prenatal vitamins							
Birth control*							
Prescribed medications*							
Other drug or medication not prescribed*							
Alcohol (any amount or form)							
Smoking (herself or in proximity)							

**** Please specify below if this box is marked***

Comments or clarifications of the above: ______________________

Any compilations during labor and delivery? NO or YES ______________________

Birth weight (if known) ______________ Length (if known) ______________

Did any of the following conditions impact you during delivery or in the first few days afterwards?	YES	NO	DON'T KNOW	Comments
Injured during delivery				
Cardiopulmonary distress				
Delivered with cord around neck				
Had trouble breathing after delivery				
Needed oxygen				
Required being placed in an incubator				
Turned blue (was cyanotic)				
Turned yellow (was jaundiced)				
Had an infection				
Had seizures				
Was given medications for any purpose				
Born with a congenital birth defect				
Hospitalized for more than 7 days				

EARLY INFANCY

Were you told as an infant you were	YES	NO	Comments
Difficult to feed			
Difficult to get to sleep			
Colicky			
Easy to comfort			
Difficult to put on a schedule			
Difficult to keep busy			
Alert			
Cheerful			
Affectionate			
Sociable			

NAME____

Overly active			
Stubborn, challenging			
Easy going			

CHILDHOOD AND ADOLESCENT BEHAVIOR AND DEVELOPMENT

At what about what age did you:

Crawl_____________________Walk_____________________Talk_____________________ Toilet Trained__________________________

Were you ever told that you had any developmental delay? NO YES - please elaborate: ______________________________

Before age seven, would you describe yourself as *or* were you described by others as:

1. Shy YES NO
2. Quiet YES NO
3. Withdrawn YES NO
4. Anxious YES NO
5. High strung YES NO
6. Overly active YES NO
7. Clumsy YES NO
8. Messy YES NO

Before the age of seven would you think that others would say that you, as a general rule you:

1. Don't pay attention to details YES NO
2. Don't pay attention as long as needed YES NO
3. Don't seem to listen YES NO
4. Don't finish things YES NO
5. Can't organize things YES NO
6. Avoid things that take a lot of effort YES NO
7. Lose things YES NO
8. Are easily distracted YES NO
9. Forget things YES NO
10. Fidget YES NO
11. Have trouble sitting still YES NO
12. Run around all the time YES NO
13. Have trouble playing quietly YES NO
14. Talk a lot YES NO
15. Blurt out answers to questions YES NO
16. Have trouble waiting your turn YES NO
17. Interrupt others YES NO
18. Don't mind your own business YES NO

Would you describe yourself as a child as, generally:

1. Not doing what adults request YES NO
2. Acting like a bully YES NO
3. Being excessively emotional YES NO
4. Being an very shy YES NO
5. Being an very outgoing YES NO

As a child were you told or do you think that you:

1. Were down or depressed? YES NO How long did this last?________________________
2. Needed to do several things in a ritualistic way? YES NO How long did this last?________________________
3. Worried excessively about many things? YES NO How long did this last?________________________
4. Had a bladder accidents? YES NO How many times?____________________________
5. Had bowel accidents? YES NO How many times?____________________________
6. Were cruel to animals? YES NO How many times?____________________________
7. Set fires when not asked? YES NO How many times?____________________________
8. Were anxious when family rituals are disrupted? YES NO How long did this last?________________________
9. Had ideas that others thought were unusual? YES NO How long did this last?________________________
10. Avoided going to public places? YES NO How long did this last?________________________
11. Claimed to be ill before going to school? YES NO How many times?____________________________
12. Had trouble getting thoughts out of your head? YES NO How long did this last?________________________
13. Had trouble falling asleep/staying asleep? YES NO How many times?____________________________
14. Had fine motor problems? YES NO How long did this last?________________________
15. Unusual changes in appetite? YES NO How long did this last?________________________

Details of above if needed: ____ ____________________________________

As a child or adult were you, to the best of your knowledge, ever:

1. A victim of a violent crime? YES NO
2. A victim of any crime? YES NO
3. Been in a place where your life was at risk? YES NO
4. Physically hurt by an adult? YES NO
5. Sexually molested? YES NO
6. Traumatized in any way? YES NO

If so, please use the space below (or additional pages) to elaborate____

____

NAME____

MEDICAL HISTORY

Date of last physical exam _________________ Date next exam is scheduled_________________

Have you ever been diagnosed with or told you have had:

1. Asthma	YES	NO	11. Broken bones	YES	NO
2. Allergies	YES	NO	12. Fevers over 104F	YES	NO
3. Diabetes	YES	NO	13. Heart or blood pressure problems	YES	NO
4. Arthritis	YES	NO	14. Head injury	YES	NO
5. Chronic illness	YES	NO	15. Loss of consciousness	YES	NO
6. Epilepsy/Seizures	YES	NO	16. Lead poisoning	YES	NO
7. Non-epileptic seizures	YES	NO	17. Surgery	YES	NO
8. HIV Infection/AIDS	YES	NO	18. Lengthy hospitalizations	YES	NO
9. Chicken Pox	YES	NO	19. Chronic ear infections	YES	NO
10. Hepatitis	YES	NO	20. Tropical Disease	YES	NO

Do you have any other medical conditions not already marked above? YES NO

If you marked YES to any of the above please elaborate:____

____

Do you have/have you ever had a mental health diagnosis?_______________________________________

Do you currently have any mental health related symptoms?______________________________________

____

Describe the reasons and durations of all the hospitalizations you have had:

1) ____
2) ____
3) ____
4) ____

Please describe ALL loss of consciousness, concussion, head injury or other head trauma:

1) ____
2) ____
3) ____
4) ____
5) ____

Have you ever had prior psychological or neuropsychological evaluation? ____ No ____ Yes – If yes:

Date(s) of evaluation: ____

Reason(s) for evaluation: ____

Result(s) of evaluation: ____

What, if any, prescribed medication(s) do you take on regular basis? (Use additional pages if needed)

Name of medication	How much (mg)	How often (Once per day, twice, three times)

Do you participate in/use alternative medical treatments such as herbs, chiropractic etc? YES NO

If so, please specify which ones and condition(s) for which seek treatment:_______________________________

____

Has any parent, sibling or biological child been diagnosed with any mental health condition? YES NO

Relationship	Type of Problem	Any Treatment (Yes or No)	Type of Treatment	Comments

NAME____

Has any other BIOLOGICAL relative been diagnosed with a mental health condition? YES NO

Relationship	Type of Problem	Any Treatment (Yes or No)	Type of Treatment	Comments

EDUCATION

Were you ever diagnosed with a learning disorder, placed in a special education or pulled out of the regular classroom for special services? NO YES If YES, please elaborate: ____
Highest level of education?:______________________Highest Degree?___________Year Earned________
Please list all formal schooling you have had/Degrees you have earned:

Ages	Grades/Degree	Name of School	Location	Public or Private?

SPORTS

Please list all sports activities participated in, starting with your earliest activity (from childhood to present).

Ages	Sport	Any injuries	Head trauma/loss of consciousness?

REINACTMENT GROUPS

Please list the reenactment groups you participate in for which you participate martial combat, as well as the length of participation in "fighting," the frequency and any related injuries. (please use back if more room is needed):

GROUP NAME (ie – Armored Combat League etc)	Type of combat (ie rattan, live steal, jousting	Length of participation (ie – 5 years)	Frequency of participation in fighting, including practice (ie 2 times week)	Injuries (please describe all major injuries sustained, including any head injuries, concussions, loss of consciousness as well as any broken bones)

Have you ever received evaluation for the head injuries listed above (Ie – PET scan, MRI, etc)?:
____

RECREATION

Briefly describe the kinds of things you do for fun or recreation (games, TV, hobbies, books attending church, etc.):
____
____
____

NAME____

CURRENT SYMPTOM CHECKLIST

Check the space next to every symptom that applies to you and whether it is new (within the last 6 months) or old (lasting longer than 6 months)

1) **PROBLEM SOLVING**

New	Old	
____	____	Difficulty planning ahead.
____	____	Difficulty figuring out problems that most other people can figure out.
____	____	Difficulty thinking as quickly as needed.
____	____	Difficulty doing things in the right order (sequencing things correctly).
____	____	Difficulty verbally describing the steps involved in doing something.
____	____	Difficulty changing a plan or activity when needed.
____	____	Difficulty completing an activity in a reasonable amount of time.
____	____	Difficulty doing more than one thing at a time.
____	____	Difficulty switching from one activity to another.
____	____	Difficulty knowing when to stop doing something.
____	____	Becoming easily frustrated.
____	____	Tending to easily give up doing something.
____	____	Other problem solving difficulties: ______________________________

2) **SPEECH, LANGUAGE, AND MATH SKILLS**

New	Old	
____	____	Difficulty finding the right word to say.
____	____	Difficulty understanding what others are saying (not because of hearing problems).
____	____	Difficulty speaking at all - unable to speak
____	____	Difficulty staying with one idea while talking.
____	____	Difficulty writing letters or words (not because of motor problems).
____	____	Slurred speech or difficulty articulating words.
____	____	Odd or unusual speech sounds.
____	____	Difficulty with math skills (adding numbers, balancing checkbooks, making change).
____	____	Difficulty understanding what you read.
____	____	Difficulty spelling words.
____	____	Other speech, language, or math problems: ______________________________

3) NONVERBAL SKILLS

New	Old	
____	____	Difficulty telling right from left.
____	____	Difficulty doing things you should be able to do automatically (brush teeth, shave, etc).
____	____	Difficulty drawing or copying figures or pictures.
____	____	Difficulty dressing correctly (not due to motor or orthopedic problems).
____	____	Problems finding your way around familiar places.
____	____	Difficulty recognizing objects or people.
____	____	Feeling that parts of your body do not belong to you.
____	____	Unaware of things on one side of your body: Left Side _______ Right Side ______
____	____	Declines in your musical abilities/preferences.
____	____	Difficulty telling time or knowing what day or season it is.
____	____	Slowed reaction time, clumsiness, uncertainty in movement.
____	____	Difficulty arranging things on order, or putting them away correctly.
____	____	Other nonverbal problems: ______________________________

NAME____

4) **CONCENTRATION, ATTENTION, AND AWARENESS**

New	Old	
___	___	Highly distractible.
___	___	Losing your train of thought easily.
___	___	Trouble concentrating.
___	___	Becoming easily confused or disoriented.
___	___	Having blackout spells (or fainting).
___	___	Blanking (suddenly realizing you don't remember what went on for the previous few minutes
___	___	Experiencing auras (strange feelings or sensations - seeing lights of halos, hearing odd sounds; roaring, ringing; smelling odd smells; burning tar).
___	___	Not feeling very alert or aware of things.
___	___	Not feelings very "present" or "on top" of things.
___	___	Feeling sleepy or detached from what is going on.
___	___	Other concentration of awareness problems: ____________________

5) **MEMORY**

New	Old	
___	___	Forgetting where you left things (keys, gloves, etc.)
___	___	Forgetting names of people you just meet.
___	___	Forgetting names of people you already know.
___	___	Forgetting what you should be doing, or why you are doing something already.
___	___	Forgetting where you are going.
___	___	Forgetting recent events (TV show, last meal).
___	___	Forgetting events that happened long ago (months or years ago)
___	___	Needing someone to give you a hint to remember things.
___	___	Relying on notes more and more to remember things.
___	___	Forgetting the order things happened in (while cooking, making things)
___	___	Forgetting facts, but knowing how to do things.
___	___	Forgetting faces of people you know (when they are not around).
___	___	Frequently forgetting appointments.
___	___	Forgetting what time it is.
___	___	Forgetting where you are.
___	___	Forgetting things you like (to eat, to do, to go to)
___	___	Other memory problems: ____________________

6) **MOTOR AND COORDINATION**

New	Old		Left	Right	Both
___	___	Fine motor control problems (writing, using keys, etc.).	___	___	___
___	___	Weakness on one side of your body.	___	___	___
___	___	Difficulty holding things.	___	___	___
___	___	Tremor or shakiness.	___	___	___
___	___	Muscle tics or twitches.	___	___	___
___	___	Bumping into things a lot	___	___	___
___	___	Writing becomes very small.			
___	___	Writing becomes very large.			
___	___	Writing becomes very shaky and unsteady.			
___	___	Walking is slower than that of other people.			
___	___	Walking is unsteady or uncertain.			
___	___	Having balance or coordination problems.			

NAME______________________________________

___ ___ When you close your eyes you feel dizzy or fall down.
___ ___ Difficulty starting to move (initiation problem).
___ ___ Jerky movements, movement is not at all smooth and supple.
___ ___ Tiring quickly, losing strength.
___ ___ Tripping or falling easily.
___ ___ Difficulty walking on uneven ground or across the face of a hill.
___ ___ Other motor or coordination problems:_______________________________________

7) **SENSORY AND PERCEPTUAL**

New Old
___ ___ Loss of feeling or numbness in one or more body parts.
___ ___ Tingling or strange skin sensations in one or more body parts.
___ ___ Difficulty telling hot from cold.
___ ___ Problems seeing things to your left or right. R___ L___
___ ___ Blurred vision or vision that accommodates slowly.
___ ___ Blank or blind spots in your visual field.
___ ___ Brief periods of blindness.
___ ___ Seeing Stars" or flashes of light.
___ ___ Double vision.
___ ___ Seeing "spangly" shapes that grow with time and make it hard to see.
___ ___ Difficulty looking quickly from one object to another.
___ ___ Needing to squint or move closer to an object to see it clearly.
___ ___ Losing hearing, or feeling that people are not talking loud enough.
___ ___ Ringing in the ears or hearing strange sounds (rumbling, buzzing, etc.)
___ ___ Having difficulty telling how foods taste.
___ ___ Having difficulty telling how things smell.
___ ___ Smelling strange odors.
___ ___ Other sensory problems:____.

8) **PHYSICAL SYMPTOMS** and **BEHAVIORAL CONCERNS**

New Old
___ ___ Headaches Describe____
___ ___ Dizziness
___ ___ Nausea or vomiting.
___ ___ Difficulty starting, stopping urine flow, or incontinence.
___ ___ Constipation or loss of bowel control.
___ ___ Excessive fatigue in spite of wanting to do things.
___ ___ Poor motivation or not wanting to do things.
___ ___ Low frustration tolerance, very short temper.
___ ___ Outbursts of temper or anger.
___ ___ Outbursts of crying.
___ ___ Panic attacks or feelings of overwhelming anxiety.
___ ___ Overwhelming feelings of sadness or depression.
___ ___ Difficulty falling asleep, staying asleep, or waking too early (circle one).
___ ___ Doing things automatically (without being aware you=re doing them).
___ ___ Becoming less inhibited, more spontaneous.
___ ___ Being socially inappropriate, self centered, or impulsive.
___ ___ Changes in sleep, eating, or sexual interest. Describe: ___________________________
___ ___ Other physical or emotional symptoms: ________________________________

there is: ___ Definitely something wrong with me.___ Possibly something wrong with me ___ Nothing wrong with me