

Stephanie T. Ho, Ph.D.
Licensed Psychologist, PSY23000
2725 Jefferson St., Suite 6-103
Carlsbad, CA 92008
760.688.9364

BACKGROUND INFORMATION

Name: _____

Have you experienced any of the following during the last year? Please check all that apply.

SLEEP PROBLEMS:

- difficulty falling asleep
- waking in the night
- nightmares/bad dreams
- don't feel rested
- sleeping too much

NERVOUSNESS/ANXIETY:

- feeling worried/nervous
- shortness of breath
- tightness in chest
- rapid heartbeat
- fears or phobias (describe):

PHYSICAL PROBLEMS:

- backaches
- headaches
- stomach problems
- high blood pressure
- irritable/spastic bowel
- other medical conditions
(describe): _____

APPETITE/EATING PROBLEMS:

- eating too much or when not hungry
- eating too little/restricting

- poor appetite
- using laxatives or vomiting
- weight gain
- weight loss

SADNESS/DEPRESSION:

- feeling down/blue/depressed
- crying spells/tearfulness
- feeling hopeless or helpless
- feeling suicidal or like giving up
- low energy or fatigue
- feeling flat/numb/dull

SEXUAL PROBLEMS:

- performance problems
- loss of interest in sex
- increased interest in sex
- difficulty with erection
- painful intercourse
- lack of pleasure in intercourse

OTHER:

- problems with concentration/memory
- problems getting motivated
- irritability
- angry outbursts
- frequent fights with others
- difficulties in relationships
- anything else? (describe):

Do you use alcohol? YES NO How many times/week? _____ No. of drinks: _____

Do you use any non-prescription drugs? YES NO

If so, which ones and how often? _____

Do you or someone close to you ever worry about your drug or alcohol use? YES NO

Previous mental health hospitalization? YES NO

If so, when and for what reason? _____

Family history of mental health or alcohol and/or drug problems? YES NO

If yes, explain: _____
