Les Fehmi, Ph.D.
317 Mt. Lucas Road
Princeton NJ 08540
609.924.0782 Fax: 609.924.0782
lesfehmi@openfocus.com
www.openfocus.com

Date: _____

Interviewer: _____

Referred By: _____

1. **NAME:**_____ **MALE/FEMALE** **BIRTH DATE: / /**

2. **ADDRESS:** _____

3. **PHONE: (HOME)**_____**(CELL)**_____**(OFFICE)** _____

4. **EMAIL:** _____

5. **MARITAL STATUS:** _____ **YEARS MARRIED:** _____

6. * **EMERGENCY CONTACT: NAME:**_____

   PHONE: _____ **RELATIONSHIP:** _____ **ADDRESS:** _____

   _____

7. **HOBBIES: (HOW DO YOU SPEND YOUR FREE TIME?)**

   _____

8. **PHYSICAL EXERCISE: (AMOUNT/TYPE AND FREQUENCY)**

   _____

Do you have any of these common symptoms? Please note their intensity and frequency. Please include all symptoms, even if you consider them unimportant.

Range: From none (0) to overwhelming (10)- (ex.,3-7)

Frequency: Times a Day (D), Week (W), Month (M), Year (Y), ex., (3xD)

PHYSICAL SYMPTOM	RANGE OF INTENSITY	FREQUENCY
COLD HANDS/FEET		
HEADACHES		
NECK, SHOULDER, BACK OR OTHER MUSCLE PAIN		
PAINS/TIGHTNESS IN CHEST OR HEART		
SWEATING HANDS/FEET, ETC.		
HIGH/LOW BLOOD PRESSURE		
NAUSEA, VOMITING, UPSET STOMACH		
DIARRHEA, CONSTIPATION		
HEART POUNDING, RACING, ARRHYTHMIAS		
MUSCLE TWITCHING OR TREMORS		
NERVOUSNESS, SHAKINESS		
EASILY FATIGUED, LOW ENERGY, BURNOUT		
DIZZINESS, VERTIGO OR FAINTNESS		
BODY NUMBNESS OR TINGLING		
EATING DISORDERS, LOSS OR INCREASE IN APPETITE		
OTHER PAIN		

BEHAVIORAL/EXPERIENTIAL SYMPTOM	RANGE OF INTENSITY	FREQUENCY
HAVING TROUBLE FALLING/STAYING ASLEEP		
UNABLE TO GET RID OF NEGATIVE THOUGHTS/IDEAS		
UNUSUAL BODY FEELINGS		
ANXIETY, FEAR, APPREHENSION, PANIC		
FEELING CRITICAL OF OTHERS		
NIGHTMARES		
STUTTERING, STAMMERING, ETC.		
TROUBLE REMEMBERING THINGS, MIND GOES BLANK		
FEELING EASILY ANNOYED, ANGERED, IRRITATED		
FEELING CONFUSED		
CRYING EASILY		
TEMPER OUTBURSTS YOU CANNOT CONTROL		
BLAMING YOURSELF FOR THINGS		
IMPULSIVE BEHAVIOR, EMOTIONAL INSTABILITY		
FIDGETY, RESTLESS, ANTSY, IMPATIENT		
FEELING LONLEY, SEPARATE, SAD		
SUBSTANCE ABUSE– FOOD, ALCOHOL, DRUGS		
FEELING NO INTEREST IN THINGS		
FEELING GUILTY, SHAME		
WANTING TO BE ALONE		
TROUBLE CONCENTRATING, DISTRACTED		
MOOD SWINGS		
FEELING HOPELESS ABOUT THE FUTURE		
DEPRESSION, WITHDRAWL, PROCRASTINATION		
FEELING SELF CONSCIOUS		
TALKING TOO MUCH		
FEELING SOMETHING IS WRONG WITH YOUR MIND		
FEELING PEOPLE ARE UNFRIENDLY OR DISLIKE YOU		
LACK OF MOTIVATION, INTEREST		
SEXUAL SHYNESS		

MEDICAL / PSYCHOLOGICAL

1. PRIMARY SYMPTOM(S) COMPLAINT(S) FOR WHICH TREATMENT IS DESIRED.

1. _____

2. _____

3. _____

2. DATE AND CONDITION SURROUNDING FIRST APPEARANCE OF EACH SYMPTOM

1. _____

2. _____

3. _____

3. WHO DIAGNOSED SYMPTOMS (NAME & ADDRESS)

WHAT WAS DIAGNOSIS _____ WHEN WAS IT DIAGNOSED_____

4. LAST PHYSICAL EXAMINATION BY PHYSICIAN _____

NAME OF PHYSICIAN _____ DATE _____

OUTCOME/RECOMMENDATIONS_____

5. CURRENT MEDICATIONS (PLEASE LIST ALL MEDICATIONS CURRENTLY USED:

SYMPTOM BEING TREATED	MEDICATION	DOSAGE	FREQUECY OF USE	EFFECTIVNESS	SIDE EFFECTS	PRESCRIBING PHYSICIAN	START DATE

6. PAST/CURRENT USE OF STIMULANTS AND SOCIAL DRUGS (CHECK AND DESCRIBE FREQUENCY)

ALCOHOL _____ CIGARETTES _____ MARIJUANA _____ COFFEE _____ TEA _____

OTHER SUBSTANCES

7. NUTRITIONAL HABITS (DESCRIPTION OF ONE DAY'S MEALS)

BREAKFAST _____

MID-MORNING SNACK _____

LUNCH _____

MID-AFTERNOON SNACK _____

DINNER _____

EVENING SNACK _____

<u>USE OF STRESS FOODS—DESCRIBE FREQUENCY</u>

SUGAR___ CANDY ___DESSERTS ___ SALT ___ CHOCOLATE ___SOFT DRINKS ___

HOW OFTEN DO YOU EAT OUT?_____

8. DESCRIBE ANY OCCASIONS WHEN YOU HAVE LOST CONSCIOUSNESS OR FAINTED

_____

9. MARITAL AND/OR FAMILY RELATIONSHOPS. WHAT ARE THE MAJOR STRESSORS IN YOUR FAMILY LIFE? _____

FATHER _____

MOTHER _____

DO YOU LIKE YOUR JOB? SCHOOL? _____

WHAT ARE THE MAJOR STRESSORS IN YOUR JOB? SCHOOL? _____

HOW WOULD YOU DESCRIBE YOUR RELATIONSHIP WITH OTHERS (FRIENDS, EMPLOYERS, EMPLOYEES)? _____

10. HOW WELL CAN YOU RELAX WHEN YOU HAVE NO SPECIAL PROBLEMS? (RATE 1-10) _____

11. HOW WELL CAN YOU RELAX WHEN YOU NEED TO RELAX (RATE 1-10)

_____

12. DO YOU DO ANYTHING SPECIFICALLY TO RELAX, I.E., HAVE YOU ANY KNOWLEDGE AND/OR EXPERIENCE WITH ANY OF THE SYSTEMATIC RELAXATION TECHNIQUES SUCH AS MEDITATION, YOGA, AUTOGENIC TRAINING, BIOFEEDBACK TRAINING, ETC.?

_____

13. WHAT DO YOU DO ON A DAILY BASIS TO SPECIFICALLY RELAX? WHEN DO YOU DO THIS AND HOW MUCH TIME DO YOU SPEND?

_____

TO BE FILLED OUT BY THERAPIST ONLY

MEDICAL/PSYCHOLOGICAL

1. **WHAT EMOTIONAL FEELING IS DOMINANT WHEN THE SYMPTOM IS PRESENT OR MOST INTENSE? (NERVOUSNESS, WORRY, FEAR, ANGER, FRUSTRATION, OTHER)**

   _____

2. **DO YOU HAVE ANY WARNING THAT THE SYMPTOM IS COMING ON OR WILL INCREASE IN INTENSITY (FEELING NERVOUS, DEPRESSED, MUSCLE TENSION, OR OTHER MENTAL OR EMOTIONAL STATE)**

   _____

3. **WHAT REDUCES OR ALLEVIATES EACH SYMPTOM? (ACTIVITY, MEDICATION, FOOD, BEVERAGES, RELAXATION, SLEEP, ETC.)**

   _____

4. **WHAT INCREASES THE SEVERITY OF EACH SYMPTOM (FOODS, STRESSFUL SITUATION, ACTIVITY, MEDICATION)**

   _____

5. **HAVE YOU NOTICED ANY TIME PATTERNS IN RELATION TO THE OCCURANCE OF YOUR SYMPTOMS? (TIME OF DAY/WEEK/MONTH, SLEEPING VS. WAKING, SEASON CHANGE, WEATHER ETC.)**

   _____

6. **HAVE YOU NOTICED THAT CERTAIN FEELINGS OR SITUATIONS MAY BE ASSOCIATED WITH THE ONSET OF SYMPTOMS? (STRESSFUL EVENTS, IMPENDING SOCIAL/ FAMILIAL/OCCUPATIONAL ENGAGEMENTS)** _____

7. HOW ARE DAILY ACTIVITES LIMITED BEFORE/DURING/FOLLOWING THE APPEARANCE OF EACH SYMPTOM?

_____

8. HOW WOULD YOUR LIFE BE DIFFERENT WITHOUT YOUR SYMPTOM (S)?

_____

9. WHAT, IF ANY, BENEFITS DO YOU RECEIVE FROM YOUR SYMPTOMS (E.G. ATTENTION FROM OTHERS, OPPORTUNITY TO TAKE IT EASY, DISTRACTION FROM PERSONAL PROBLEMS)?

_____

10. DETAILED DESCRIPTION OF SYMPTOM(S) COMPLAINT (S) FOR WHICH BIOFEEDBACK TRAINING IS DESIRED. FOR EACH SYMPTOM:

SYMPTOM	LOCATION	QUALITY OF PAIN	INTENSITY	DURATION	FREQUENCY

11. DO YOU EXPERIENCE SUICIDAL THOUHTS? _____

HAVE YOU EVER ATTEMPTED SUICIDE?_____

DO YOU THINK YOU MIGHT EVER ATTEMPT SUICIDE?_____