DR. SONA KAKAR, M.D.
Centre For Emotions
Begumpet, Chikoti Garden, Opp: Shopper Stop line.
Mob: 9100221111

CONFIDENTIAL

Adult Intake Questionnaire

In order for us to be able to fully evaluate you, please fill out the following intake form and questionnaires to the best of your ability. We realize there is a lot of information and you may not remember or have access to all of it; do the best you can. If there is information you do not want in your medical chart it is ok to refrain from putting it in this information. Thank you!

PATIENT IDENTIFICATION

Name _____ First Appointment Date _____

Birth Date _____ Age _____ Sex _____Employer _____

Occupation _____ Marital Status _____

Address _____ City _____ State ____ Zip _____

E-Mail Address _____ Home Phone # _____Cell/Work # _____

Parent's Phone and Contact Information (if relevant): _____

Children (names/age)_____

Who lives with you, currently (names/relationship)? _____

_____

Referred here by whom:_____ Phone:_____

Primary Care:_____ Phone:_____

Additional Care:_____ (Why did you seek the evaluation at this time? What Phone:_____

MAIN PURPOSE OF THE CONSULTATION

are your goals in being here?)

_____

_____

Most Prominent Problems **How Long**

1._____

2._____

3._____

4. _____

5. _____

How were you before these problems occurred (if relevant)?

_____

_____

Previous symptoms throughout your entire life:

_____

_____

Current medications for these problems, reasons for taking them, and their effects on you:

_____

_____

How much time and money have you spent on your primary problem(s)?

_____

_____

How will you know you are done?

_____

_____

MEDICAL HISTORY

Present Height _____ *Present Weight* _____
PRIOR PSYCHOTHERAPY/PSYCHIATRIC HISTORY
(Please include contact with other professionals, medications, types of treatment, etc.)

_____

_____

_____

Current **medical problems/medications**:_____

_____

Current supplements/vitamins/herbs:_____
Past medical problems/medications: _____

_____

Other doctors/clinics seen regularly: _____

Any history of head trauma? (describe): _____

_____

Ever any seizures or seizure like activity? _____

Prior hospitalizations (place, cause, date, outcome): _____
Prior abnormal lab tests, X-rays, EEG, etc: _____
Allergies/drug intolerances (describe): _____

_____

Sleep difficulties & behavior: Early awakening, trouble falling asleep, unable to resume sleep, sleepwalking, nightmares, recurrent dreams, other current problems (circle, then detail problem) _____

_____

_____

CURRENT LIFE STRESSES (include anything that is currently stressful for you, examples include relationships, job, school, finances, children. Continues on next page) _____

_____

_____

_____

_____

School History: Last grade completed _____ Last school attended _____
Average grades received _____ Specific learning disabilities _____
Learning strengths _____
Any behavior problems in school? _____
What have teachers said about you?_____
Please bring school report cards and any state, national or special testing that has been performed.

Employment History: (summarize jobs you've had, list most favorite and least favorite)

_____
_____
_____

Any work-related problems? _____

What would your employers or supervisors say about you? _____

_____

Military History? _____

Ever Any Legal Problems? _____

_____

Alcohol and Drug History: (Please list age started and types of substances used through the years and any current usage. Also, describe how each of these substances made you feel; what benefit you got from them.). These include alcohol (hard liquor, beer, wine), marijuana or hash, prescription tranquilizers or sleeping pills, inhalants (glue, gasoline, cleaning fluids, etc.), cocaine or crack, amphetamines or crank or ice, steroids, opiates (heroin, codeine, morphine or other pain killers), barbiturates, hallucinating drugs (LSD, mescaline, mushrooms), PCP.

_____

_____

_____

Do you have a medical marijuana card? _____If yes, for what condition? _____
Do you or have you ever experience withdrawal symptoms from alcohol or drugs? _____
Has anyone told you they thought you had a problem with drugs or alcohol? _____
Have you ever felt guilty about your drug or alcohol use? _____
Have you ever felt annoyed when someone talked to you about your drug or alcohol use? _____
Have you ever used drugs or alcohol first thing in the morning?_____
Caffeine use per day (caffeine is in coffee, tea, sodas, chocolate) _____
Nicotine use per day, past and present, (nicotine is in cigarettes, cigars, tobacco chew [circle use])

_____

Sexual history: (answer only as much as you feel comfortable)

History of sexual abuse, molestation or rape?

_____

Current sexual problems?_____

History of being physically abused: _____

Cultural/ethnic background _____

_____

Describe yourself/your strengths in a few words:

Family Structure (who lives in your current household, please give relationship to each):

_____

_____

_____

Current Marital or Relationship Satisfaction_____

_____

_____

Significant Developmental Events (include marriages, separations, divorces, deaths, traumatic events, losses, abuse, etc.)_____

_____

_____

_____

Natural Mother's History: age_____ occupation _____
School: highest grade completed _____
Learning problems _____
Behavior problems _____
Marriages _____
Medical Problems _____
Her childhood atmosphere (family position, abuse, illnesses, etc)_____
_____
Has mother ever sought psychiatric treatment? Yes ___ No ___ If yes, for what purpose? _____
_____

Mother's alcohol/drug use history _____
Have any of your mother's blood relatives ever had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalizations? (specify)
_____

_____

Natural Father's History: age_____ occupation _____
School: highest grade completed _____
Learning problems _____
Behavior problems _____
Marriages _____
Medical Problems _____
His childhood atmosphere (family position, abuse, illnesses, etc)_____
_____
Has father ever sought psychiatric treatment? Yes ___ No ___ If yes, for what purpose? _____
_____
Father's alcohol/drug use history _____

Have any of your father's blood relatives ever had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalizations? (specify)
_____

_____

Your Siblings (names, ages, problems, strengths, relationship to patient) _____

_____

_____

Your Children (names, ages, problems, strengths) _____

_____

_____

Quick Assessment (QA, JD Elder**)**

Name of Patient: _____ **Name of Rater (if not self):** _____ **Date:** _____

Please rate yourself, or the person you are assessing, for each of symptoms below. Check only one box on the rating scale for each symptom. If you don't know how to rate a symptom leave it blank.

Rating Scale (Frequency of Symptoms)

Low Frequency Rating: 0 = None -- has not occurred during the last month.
1 = Monthly -- has occurred one or more times during the last month, but not within the last week.

High Frequency Rating: 2 = Weekly -- has occurred one or more times during the last week, but not daily.
3 = Daily -- has occurred daily for the last seven days.

Symptoms	None 0	Monthly 1	Weekly 2	Daily 3
Anxious, fearful, uneasiness, worry, concern				
Inattention, daydreaming, hard to stay on task				
Sad and Blue, guilt, helpless, hopeless feelings				
Dull, slow to learn, not sharp				
Forgetful, failure to recall or remember				
Spaciness, fogginess, not tuned in				
Disrupted Sleep, wakes often, difficulty waking				
Cries Easily, sheds tears, weeps easily				
Feelings Easily Hurt, vulnerable				
Low Self-esteem, poor self-confidence				
Lack of Motivation, discouraged				
Confused Thinking, mixed up, baffled				
Nausea, sickness, upset stomach				
Loss of Emotional Control, rage, wrath				
Lethargic, lazy, drowsy, sluggish, fatigue				
Left Subtotals				

Symptoms	None 0	Monthly 1	Weekly 2	Daily 3
Racing Thoughts, many thoughts				
Agitation, upset, disturbed				
Hyperactive, excessive movement				
Difficulty Falling Asleep, insomnia				
Impulsive, spontaneous urge				
Physical Tension in Body, taut, nervous, tense				
Pressure in Chest, discomfort, pain in chest				
Aggressive, hostile, overly assertive, bold				
Teeth Grinding, jaw clenching, tight jaw				
Headaches, feeling discomfort, unusual feeling				
Crawling Sensations on Skin, leg twitches				
Sensitivity to Touch, hands, feet, face				
Pain Awareness, long unpleasant sensation				
Hyper Focused, overly attentive, very focused				
Sad and Angry, agitated and feeling blue				
Right Subtotals				

Grand Total **Left Total** **Right Total**

DEPRESSION RESILIENCE (Baseline)

adapted from Judd et al 2016

--- Feeling blocked in getting things done

--- Feeling pushed to get things done

--- Feeling tense or keyed up

--- Having ideas/beliefs others do not share

--- Feeling inferior to others

--- Feeling low in energy or slowed down

--- Feeling self-conscious with others

--- Headaches

--- Crying easily

--- Feelings being easily hurt

--- Worrying too much about things

--- Trouble concentrating

MOOD INVENTORY (BECK)

These sentences are listed together in groups. After you have read one group of sentences, **pick out ONE in the group** that describes the best pick that describes how you feel. Think about the way you have been feeling **thi s pas t week.**

After you pick your answer from the first group of sentences, go on the next group of sentences. there is no such thing as a right answer or a wrong answer. Just pick the answer that describes you best.

PLEASE CHECK THE NUMBER NEXT TO THE SENTENCE THAT IS YOUR ANSWER.

1) 0 I do not feel sad.

1 I feel sad.
2 I am sad all of the time and I can't snap out of it.

3 I am so sad or unhappy that I can't stand it.

2) 0 I am not particularly discouraged about the future.

1 I feel discouraged about the future.

2 I feel I have nothing to look forward to.

3 I feel that the future is hopeless and that things cannot improve.

3) 0 I do not feel like a failure.

1 I feel I have failed more than the average person.
2 As I look back on my life, all I can see is a lot of failures.

3 I feel I am a complete failure as a person.

4) 0 I get as much satisfaction out of things as I used to.

1 I don't enjoy things the way I used to.

2 I don't get real satisfaction out of anything anymore.

3 I am dissatisfied or bored with everything.

5) 0 I don't feel particularly guilty.

1 I feel guilty a good part of the time.
2 I feel guilty most of the time.

3 I feel guilty all of the time.

6) 0 I don't feel I am being punished.

1 I feel I may be punished.

2 I expect to be punished.

3 I feel I am being punished

7) 0 I don't feel disappointed in myself.

1 I am disappointed in myself.
2 I am disgusted with myself.

3 I hate myself.

8) 0 I don't feel I am any worse than anybody else.

1 I am critical of myself for my weaknesses or mistakes.

2 I blame myself all the time for my faults.

3 I blame myself for everything bad that happens.

9) 0 I don't have any thoughts of killing myself.

1 I have thoughts of killing myself.
2 I would like to kill myself.

3 I would kill myself if I had the chance.

10) 0 I don't cry any more than usual.

1 I cry more now than I used to.
2 I cry all the time now.

3 I used to be able to cry, but now I can't cry even though I want to.

11) 0 I am no more irritated now than I ever am.

1 I get annoyed or irritated more easily than I used to.

2 I feel irritated all the time now.

3 I don't get irritated at all by the things that used to irritate me.

12) 0 I have not lost interest in other people.

1 I am less interested in other people than I used to be.
2 I have lost most of my interest in other people.

3 I have lost all of my interest in other people.

13) 0 I make decisions about as well as I ever could.

1 I put off making decisions more than I used to.
2 I have greater difficulty in making decisions than before.

3 I can't make decisions at all anymore.

14) 0 I don't feel I look any worse than I used to.

1 I am worried that I am looking old or unattractive.

2 I feel that there are permanent changes in my appearance that make me look unattractive.
3 I believe that I look ugly.

15) 0 I can work about as well before.

1 It takes an extra effort to get started at doing something.
2 I have to push myself very hard to do anything.

3 I can't do any work at all.

16) 0 I can sleep as well as usual.

1 I don't sleep as well as I used to.

2 I wake up 1-2 hours earlier than usual and I find it hard to get back to sleep.
3 I wake up several hours earlier than I used to and cannot get back to sleep.

17) 0 I don't get more tired than usual.

1 I get tired more easily than I used to.

2 I get tired from doing anything.

3 I am too tired to do anything.

18) 0 My appetite is no worse than usual.

1 My appetite is not as good as it used to be.
2 My appetite is much worse now.

3 I have no appetite at all anymore.

19) 0 I haven't lost much weight, if any, lately.

1 I have lost more than 5 pounds.
2 I have lost more than 10 pounds.

3 I have lost more than 15 pounds.

I am purposely trying to lose weight by eating less. Yes____ No____

20) 0 I am no more worried about my health than usual.

1 I am worried about physical problems such as aches and pains; or upset stomach or constipation.
2 I am very worried about physical problems and it's hard to think of much else.

3 I am so worried about my physical problems, that I cannot think about anything else.

21) 0 I have not noticed any recent changes in my interest in sex.

1 I am less interested in sex than I used to be.

2 I am much less interested in sex now.
3 I have lost interest in sex completely.

The Bipolar Spectrum Diagnostic Scale R. Pies

Please read the following statements. Which seems to apply to you?

Some individuals notice that their mood and/or energy levels shift drastically from time to time.

☐

These individuals notice that, at times, their mood and/or energy level is very low, and at other times, very high.

During their “low” phases, these individuals often feel a lack of energy, a need to stay in bed or get extra sleep, and little or no motivation to do things they need to do. They often put on weight during these periods.

During their low phases, they feel hopeless or even suicidal. Their ability to function at work

or socially is impaired.

Typically, these low phases last for a few weeks, but sometimes they last only a few days.

Individuals with this type of pattern may experience a period of “normal” mood in between mood swings, during which their mood and energy level feels “right” and their ability to function is not disturbed.

Their energy increases above what is normal for them, and they often get many things done that they would not ordinarily be able to do.

- Sometimes, during those “high” periods, these individuals feel as if they have too much energy or feel “hyper.”
- Some individuals, during these high periods, take on too many activities at once.
- During these high periods, some individuals may spend money in ways that cause them trouble.
- They may be more talkative, outgoing or sexual during these periods.
- Sometimes, their behavior during these high periods seems strange or annoying to others.
- Sometimes, these individuals get into difficulty with co-workers or police during these high periods.
- Sometimes, they increase their alcohol or nonprescription drug use during these high periods.

☐

☐

Now that you have read the passage, please check one of the following four boxes.

☐ This story fits me very well, or almost perfectly.

☐ This story fits me fairly well.

☐ This story fits me to some degree, but not in most respects.

☐ This story doesn't really describe me at all.

Now please go back and put a check after each sentence that definitely describes you.

Scoring: Each sentence checked is worth one point. Add six points for "fits me well," 4 points for "fits me fairly well" and two points for "fits me to some degree." Threshold for positive diagnosis: score of 13 or above.

Fees and Cancellation Arrangements

I understand that fees are due at the time of service unless other arrangements have been made with Dr. SONA KAKAR.

I am responsible for fees for all scheduled sessions. I understand that cancellations do not cancel my agreement to pay. THERE IS NO "24-HOUR" CANCELLATION UNDERSTANDING. However, if my vacant time can be filled by another patient, I am no longer obligated to pay for missed time. WITH AN ADVANCE NOTICE WITHIN **THREE (3) BUSINESS DAYS**, DR. SONA KAKAR WILL NOT CHARGE FOR A MISSED APPOINTMENT.

SIGNED: (Patient, or Parent, if Minor) _____ DATE _____

CONSENT TO VIDEO RECORDING

In connection with services from DR. SONA KAKAR, M.D., I consent to Dr. SONA KAKAR video record of our Consultation/Psychotherapy under the following conditions of **strict confidentiality**:

1. The video recording and review process for professional self-assessment and life-long professional learning is a developing Standard of Excellence in psychotherapy services encouraged and practiced by Dr. Sona Kakar.

2. **Video recording may made only with the mutual consent and knowledge of myself and Dr. SONA KAKAR.** Video recordings are the property of Dr. Sona Kakar and will be used for educational purposes only. While this consent form may be contained in my medical records, the video recordings themselves are not available to any party who may obtain access to my medical record. Video recording is an inclusive term whether formatted on tape or digital medium.

3. With additional permission, video recording may be used selectively for instruction and **advanced continuing education of psychiatrists and other licensed psychotherapists**. It is understood that I (patient) will never be identified by name and that all professional observers are bound to strict professional confidentiality. ***If you are willing make such a contribution to others' training, please initial and date here****. (initials)* _____ *(date)* _____

Unless retained in educational/research archive, video recordings are erased after review. Any retained video recordings will be destroyed upon Dr. Sona Kakar death.

My agreement to take part in this video recording is completely voluntary. I understand that I may revoke this authorization at any time without jeopardizing my treatment.

Print Name: _____ **Signature** _____ **Date**:_____