# Demographic Information, Part I

1. What is your First Name?

First name

2. What is your Last Name?

Last name

3. What is your date of birth?

01-01-2000

4. Please select any of the following that represent your race or ethnicity. You may select more than one.

caucasian,other,east indian

5. What sex was assigned to you at birth?

female

6. What pronoun do you currently prefer?

she/her/hers

7. What is your marital status?

divorced

8. What is your email?

person@people.com

9. What is your phone number?

111-111-1111

# Employment Where the Physical or Emotional Injury Occurred

10. Name of your current employer:

IBM

11. What is the nature of this business:

computers

12. Date this job began:

1/1/2004

13. What was the last day you worked at this job?

1/1/2023

14. Your job title when you started this employment:

programmer

15. Your current title or title when you ended this employment:

manager

16. Your employment duties:

turn computers on and off

17. Your typical work schedule (hours worked per day, week, or month):

40 hours a week

18. Your salary:

$1,000,000

Hourly Rate:

$1,000

Do you receive overtime pay?

Yes

How much overtime pay do you typically receive?

$100

19. What do you like about this job?

Lots of money

20. What do you not like about this job?

I don't like computers

21. BEFORE the injury, were you being treated for any physical or medical condition(s)?

Yes

22. BEFORE the injury, were you being treated for any mental or emotional condition(s)?

Yes

23. BEFORE the injury, were you experiencing any emotional symptoms?

Yes

24. Describe these medical or emotional conditions or symptoms BEFORE the injury:

I couldn't walk. I was depressed.

25. Were you taking any medications BEFORE the injury?XXX

26. What medications were you taking BEFORE the injury?

Morphine

27. Date of your injury (if more than one, list each):

1/1/2004, 2/1/2014, 3/1/2022

28. Describe the injury that occurred (provide as many details as you can):

I hate my boss and he's mean to me.

29. Do you currently receive disability in connection with your claim?

Yes

If Yes, Which Current Disability:

partial Temp

30. Would you have continued working if not injured?

Yes

31. Are you currently working

Yes

32. Have you had any conflicts with anyone at Work

Yes

How many separate conflicts have you had with others at work

4

Please list separately and explain each conflict that occurred:

1. my boss was mean, 2. my coworker stole my stuff, 3. the customers suck, 4. It's too hot and my boss won't turn on the AC

Please rate the percentage that each of these conflicts caused you to feel upset, out of total of 100% (Example: Conflict #1 30%, #2 50%, #3 20%)

1. 20%, 2, 30%, 3. 10%, 4. 40%

33. What was/is your working relationship like with management or supervisors in general?

terrible

34. Name of your immediate supervisor:

bad boss

35. Relationship with immediate supervisor?

poor

Explain the reason:

they're mean

36. How were your performance appraisals?

poor

Explain reason

they said i can't do my job well

37. Have you ever received verbal or written warnings?

Yes

Describe dates and reason given:

1/1/2022 they said I suck at my job

38. Working relationship with co-workers?

poor

Please give the names and reasons this relationship was poor.

they're stupid

39. Was there a 'last straw' event near the last day of work?

Yes

Please describe your 'last straw' event near the last day of your work

It was too hot.

# Current Employer (If Different Than Above)

40. Do you currently work for the same employer where the above injury occurred?

No

Name of current employer:

Give me a house

Nature of business:

housing

Job title:

squatter

Job duties:

find houses

Date this job began:

8/1/23

Your schedule, hours worked per (day, week, month):

weekends 9-5

Salary or hourly rate:

$5/hr

Do you like this job?

No

# Physical Injury

41. If your injury was initially physical, describe the first symptoms (pain) you experienced:

knees hurt

42. If your injury was initially physical, describe the first treatment you received following this injury (medical, chiropractic, physical therapy pt, injections):

injections

43. If your injury was initially physical, describe the rest of your treatment (medical, chiropractic, pt)

medications

44. List the doctors you have seen for this physical injury:

Dr. Smith, Dr. Jones

45. Did you receive surgery for this injury?

Yes

46. List the surgeries you have received for this physical injury:

elbow

47. List the medications you have received for this physical injury:

Vicodin

48. Have any of the above treatments helped relieve your pain?

Yes

49. Are you still working?

Yes

50. If not working, reason for leaving?

N/A I'm working

# Emotional Symptoms and Injuries

51. I am most bothered on this day by the following:

my boss

52. What emotional symptoms are you currently experiencing or recently experienced?

anxiety,panic,depression,post-traumatic stress,mania,hypomania,psychosis,other

When did this current episode of these emotional symptoms begin?

several months ago

53. Have you experienced any of your above emotional symptoms in response to a specific stressful event in your life?

Yes

What was the stressful event that triggered your emotional symptoms?

My boss was mean to me.

54. Do you have stress from any of the following?

loss of a job or other financial changes,unstable housing,death or loss of a friend or relative,relationship stress such as friends, significant others, or family members,housing, career changes, new children and other family changes

# Longitudinal History

55. When did this episode of your depression, anxiety, or post-trauma emotions start?

7/1/23

56. Describe the emotional/psychiatric symptoms you have experienced

depressed, anxiety, stress, anger

57. During this current or most recent symptom episode, when were your symptoms the worst?

yesterday

58. Have your emotional symptoms become worse or better since they started or since a specific date or event?

worse

59. On what date did your emotional symptoms become worse or better?

7/4/23

60. How often do you feel the above emotions?

all day every day

61. How would you rate your depressive, anxiety, or post-trauma symptoms when they were most severe, with zero to 1 equaling no or minimal symptoms and 10 equaling the most severe symptoms imaginable?

Depressive: 10

Anxiety: 9

PostTrauma: 8

62. Currently, how do you rate your depressive, anxiety, or post-trauma symptoms on the same 1-10 scale?

6

63. Have Your Emotional Symptoms Affected Your Ability to Do Your Job?

Yes

Please describe how your emotional symptoms have affected your ability to do your job?

low energy, get sad, can't focus

# Current Symptoms

# PHQ-9

64. Little interest or pleasure in doing things?

several days

If you have lost the ability to enjoy activities that were previously enjoyable, please list those activities that you used to but no longer enjoy.

biking

65. Feeling down, depressed, or hopeless?

more than half the days

Have your depressive symptoms improved, become worse, or stayed the same since they started?

gotten worse

How often do you feel depressed during this or your most recent episode?

several days per week

When you experience depression, does it last a majority of the day for most days of the week?

Yes

66. Over the last 2 weeks, have you had trouble falling or staying asleep, or sleeping too much?

several days

How many times do you wake up per night before the time you plan to wake up?

two

If trouble staying asleep, when you wake up during the night, how long do you stay awake for?

1-2 hours

Do any of the following awaken you from sleep?

physical pain

What is the total number of hours you sleep per 24 hours?

4-6 hours

67. Over the last 2 weeks, have you been feeling tired or having little energy?

several days

68. Over the last 2 weeks, have you had poor appetite or been overeating?

more than half the days

If you have gained or lost weight recently, how many pounds have you gained or lost?

gained 36-50+

How long did it take you to gain or lose this weight?

1-3 months

69. Over the last 2 weeks, have you been feeling bad about yourself — or that you are a failure or have let yourself or your family down?

nearly every day

70. Over the last 2 weeks, have you had trouble concentrating on things, such as reading the newspaper or watching television?

several days

71. Over the last 2 weeks, have you been moving or speaking so slowly that other people could have noticed? Or so fidgety or restless that you have been moving a lot more than usual?

more than half the days

72. Over the last 2 weeks, have you had thoughts that you would be better off dead, or thoughts of hurting yourself in some way?

nearly every day

73. In the past month, have you wished you were dead or wished you could go to sleep and not wake up?

more than half the days

74. In the past month, have you had any actual thoughts of killing yourself?

Yes

Have you been thinking about how you might kill yourself?

Yes

Have you had these thoughts, and had some intention of acting on them?

Yes

Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?

Yes

75. Have you ever done anything, started to do anything, or prepared to do anything to end your life?

Yes

76. Do you have thoughts of hurting anyone else?

Yes

77. With zero to 1 equaling no or minimal symptoms and 10 equaling the most severe symptoms possible, how do you rate your current depressive symptoms?

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# GAD-7

78. Over the last 2 weeks, how often have you been feeling nervous, anxious, or on edge

several days

How long have you felt anxious during this or your most recent episode?

several months

How often do you feel anxious?

several days per week

79. Over the last 2 weeks, how often have you been not being able to stop or control worrying

more than half the days

80. Over the last 2 weeks, how often have you been worrying too much about different things

several days

What do you worry about?

physical pain,employment situation,financial situation,relationships,family difficulties,family death,previous trauma,conflicts with family or at employment,medical condition,other

Does anything specific make your anxiety worse?

going to work

81. Over the last 2 weeks, how often have you been trouble relaxing

several days

82. Over the last 2 weeks, how often have you been being so restless that it's hard to sit still

several days

83. Over the last 2 weeks, how often have you been becoming easily annoyed or irritable

more than half the days

84. Over the last 2 weeks, how often have you been feeling afraid as if something awful might happen

more than half the days

85. With zero to 1 equaling no or minimal symptoms and 10 equaling the most severe symptoms possible, how do you rate your current anxiety symptoms?

2

86. Over the last 2 weeks, how often have you been experience panic attacks, in which your heart races, you feel like you can't breathe, you shake or sweat?

Yes

If you experience panic attacks, indicate the physical symptoms that occur.

increased heart rate,shortness of breath,difficulty swallowing,excessive sweating,lightheadedness,feeling like going to pass out,shaking,feeling of choking,nausea,chest pain,chills or heat,numbness or tingling,feeling detached,fear of “going crazy”,fear of dying

If you experience panic attacks, how often do they occur?

once a week

If you experience panic attacks, how long do they last?

31-60 minutes

Please list anything that triggers your panic attacks:

being around my boxx

Are your panic attacks spontaneous and unrelated to any events?

Yes, my panic attacks are unrelated to specific events

87. Have you experienced past traumatic event(s)

Yes

What traumatic event(s) did you experience?

childhood trauma,intimate partner violence,victim of other violence,sexual assault,witnessing violence,first responder trauma,traumatic loss of loved ones,military combat,other

If you feel comfortable, please describe your traumatic experiences:

my boss was mean to me

# PCL-5

88. Repeated, disturbing, and unwanted memories of the stressful experience?

a little bit

89. Repeated, disturbing dreams of the stressful experience?

moderately

These disturbing dreams occur

several times per week

90. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?

moderately

91. Feeling very upset when something reminded you of the stressful experience?

moderately

92. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?

a little bit

93. Avoiding memories, thoughts, or feelings related to the stressful experience?

extremely

94. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?

extremely

Please describe the people, places, conversations, objects, or situations you avoid:

being around my boss

What activities do you avoid, in relation to the trauma you have experienced?

working

95. Trouble remembering important parts of the stressful experience?

a little bit

96. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?

moderately

97. Blaming yourself or someone else for the stressful experience or what happened after it?

quite a bit

98. Having strong negative feelings such as fear, horror, anger, guilt, or shame?

extremely

99. Loss of interest in activities that you used to enjoy (although this is a repeat question, please answer again)?

moderately

100. Feeling distant or cut off from other people?

extremely

101. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?

extremely

102. Irritable behavior, angry outbursts, or acting aggressively?

quite a bit

103. Taking too many risks or doing things that could cause you harm?

extremely

104. Being “superalert” or watchful or on guard?

quite a bit

105. Feeling jumpy or easily startled?

extremely

106. Having difficulty concentrating (although this is a repeat question, please answer again)?

extremely

107. Trouble falling or staying asleep (although this is a repeat question, please answer again)?

quite a bit

108. With zero to 1 equaling no or minimal symptoms and 10 equaling the most severe symptoms possible, how do you rate your current post-trauma related symptoms?

6

# Current Treatment

109. Do you currently take any psychiatric medications.

Yes

Please list the name(s), dose(s), and how often you take each of these medications.

morphine every day, a lot

How long have you been taking this medication?

10 years

What is the reason you take these medications you listed above? Select all that apply.

depression,anxiety,mania,psychosis,PTSD,OCD,other

Please explain the reason you take these medications you listed above.

my boss makes me depressed

The current medications you take have produced the following effects on your condition:

depression:worsened symptoms, anxiety:improved symptoms, mania:no effect on symptoms, psychosis:no effect on symptoms, PTSD:improved symptoms, OCD:worsened symptoms, other:just right

Do you always take the medication as prescribed by your medical provider?

No

Have you experienced any of the following side effects from your medication(s)?

upset stomach/nausea,diarrhea,constipation,insomnia,fatigue,headache,sexual dysfunction,shaking, stiffness, tremors,weight gain,weight loss,withdrawal,other

You selected 'other,' please describe your side effects here.

don't want to go to work

Your current or most recent psychiatric medication treatment provider was (name/facility/clinic):

Dr. Jones

110. Are you currently in psychotherapy treatment?

Yes

When did your current psychotherapy treatment begin?

10 years ago

When was your most recent psychotherapy session?

yesterday

I attend psychotherapy sessions:

weekly

Your current or most recent psychotherapy treatment provider is (name/facility/clinic):

Mr. Therapy

# Past History

111. Have you ever previously experienced any of the following symptoms

anxiety

Please describe your post traumatic stress symptoms at that time:

worried about my work

112. Have you ever experienced having so much energy that you do not need to sleep for several days or a week at a time?

Yes

During this time, if you slept fewer than 4 hours per night, how many nights did it last?

5-7 nights

During this time of lack of sleep, how was your energy when awake?

normal energy

During this time that you slept fewer than 4 hours per night for 4-7 or more consecutive nights, did you feel excessively tired during the day?

Yes

During this time, how was your mood?

depressed

During this high energy time did you engage in any high-risk behaviors?

Yes

During this time, did you drink alcohol or use any other substances?

Yes

113. Have you ever experienced any of the following?

had thoughts, behaviors, or rituals that are recurrent, intrusive, and time consuming,felt like people you don't know are talking about you or following you,heard a voice that no one else hears

When experiencing these symptoms, were you drinking alcohol or using any substances?

No

114. Recently, have you been thinking about how you might harm or kill yourself?

Yes

115. Have any of your emotional symptoms (sadness, depression, anxiety) had a negative effect upon your work, school, or relationships?

Yes

116. If you have ever experienced symptoms of depression, when did you first feel depressed?

20 years ago

117. If you have ever experienced symptoms of anxiety, when did you first feel high levels of anxiety?

10 years ago

118. Have you ever been diagnosed by a healthcare provider with any of the following mental health conditions?

anxiety,autism Spectrum Disorder,bipolar disorder,depression,eating disorder,mood disorder,obsessive compulsive disorder,personality disorder,mania or hypomania,panic attacks,schizophrenia or other psychotic disorder,post-traumatic stress disorder,other

Please enter your mental health conditions here.

Mean Person Disorder

119. Have you ever taken any other medications in the past for a psychiatric or mental health condition, not listed above? This may include medications that did not work well or that were stopped for other reasons.

Yes

Please list the name(s) of the past medication(s), dose(s), and how often you took the medication.

Oxy for 10 years in the 80s

Please list the approximate date you started taking the medication (if applicable)

1985

Please list the approximate date you stopped taking the medication (if applicable)

1989

These past psychiatric medication produced:

depression:no effect on symptoms, anxiety:worsened symptoms, mania:improved symptoms, psychotic symptoms:no effect on symptoms, PTSD:no effect on symptoms, OCD:improved symptoms, other:made me sleepy

Past psychiatric medications were stopped due to:

no longer working,no longer wanted to take them,cost,ending treatment with that prescriber,medication side effects,concerns about the medication,felt the medication was no longer needed,psychiatric symptoms had resolved,other

Did a psychiatrist, psychiatric nurse practitionaer, or primacy care clinician prescribe this medication to you?

I don't know

Please list the name(s) of your past clinician(s) who prescribed these medication(s) and dates you saw them.

Dr. Pills

At what clinic or office did they work at?

Pull pusher hospital

Please list any other psychiatrists you have ever seen.

Dr. Psychiatry

From what date(s) to what date(s) did you see these psychiatrists?

2000-2010

During this psychiatric treatment, how often did you attend sessions with your psychiatrist?

monthly

120. Have you ever previously received psychotherapy (talk therapy/counseling)?

Yes

If you have ever received psychotherapy, when did your psychotherapy begin?

1980

How long did you receive psychotherapy?

several months

During this psychotherapy treatment, how often did you attend these sessions:

monthly

Please list the names of your past psychotherapists and dates you saw them.

1980-1985

Please describe any other psychotherapy treatment not listed above:

1990-1999

121. Have you ever been admitted to a psychiatric hospital?

Yes

Please list the reason for the psychiatric hospitalization

worsening of depressive symptoms,suicidal ideation,suicide attempt,worsening of anxiety symptoms,worsening of post traumatic symptoms,worsening of manic symptoms,worsening of psychotic symptoms,I don't know

Please list the treatment you received during the psychiatric hospitalization

psychiatric medications

Please list the name(s) of the hospital you were admitted to. If there is more than one instance, please list the information for all admissions.

Hospital one, Hospital two, hospital three

Please list the dates or year(s) in which you were hospitalized

1993, June 2023

Please list how long you were hospitalized on each occasion

20 days for the first, 10 days for the second.

122. Have you ever experienced suicidal ideation?

Yes

123. Have you ever made a suicide attempt?

Yes

If yes, how many times have you attempted suicide?

6

How did you attempt suicide (list all methods ever used)?

hanging, stabbing, OD on my meds.

When was the most recent time you attempted suicide?

6 months ago

124. Have you ever experienced any other psychiatric symptoms that are not described above

Yes

Please describe the psychiatric symptoms you experienced that were not previously identified above:

ADHD

125. Have you received any other psychotherapy or psychiatric medication treatment besides that described above?

Yes

Please describe the additional psychotherapy or psychiatric medication treatment that was not described above

Ritalin as a kid.

126. Have you ever been evaluated otherwise by psychiatrists or psychologists for any other purpose?

Yes

Please describe the reason for this psychiatric or psychotherapy evaluation.

Conduct disorder.

Who performed this evaluation?

child psychiatrist

When did this evaluation occur?

I was 12 years old.

127. Have you ever been involved in physical altercations or violence?

Yes

How many physical altercations have you been involved in?

12

# Substance Use

128. Have you ever used any of the following substances?

caffeine (coffee, pills, soft drinks, etc),alcohol,tobaco or nicotine products,cocaine,heroin,prescription pain medications

How often do you currently use each substance?

caffeine (coffee, pills, soft drinks, etc):Never, alcohol:Never, tobaco or nicotine products:Never, cocaine:previously but has not recently, heroin:daily, prescription pain medications:weekly, marijuana:socially (1-2 per month), methamphetamine or other stimulants:never, MDMA, PCP, or other club drugs:socially (1-2 per month), LSD or other hallucinogens:weekly

Please list how much you use of each substance.

caffeine (coffee, pills, soft drinks, etc):2 cups, alcohol:pint a day, tobaco or nicotine products:1 pack per day, cocaine:8 ball, marijuana:1/8 a day

Please list how old you were when you started using each substance.

caffeine (coffee, pills, soft drinks, etc):12, alcohol:16, marijuana:25

When did you last use each of these substances?

caffeine (coffee, pills, soft drinks, etc):today, alcohol:yesterday, heroin:week ago, marijuana:today

Do you have a history of experiencing tolerance (needing more to get the same effect) from any of the following substances?

caffeine (coffee, pills, soft drinks, etc):Yes, alcohol:Yes, tobaco or nicotine products:Yes, cocaine:Yes, heroin:Yes, prescription pain medications:No, marijuana:No, methamphetamine or other stimulants:Yes, MDMA, PCP, or other club drugs:No, LSD or other hallucinogens:No

Do you have a history of experiencing withdrawal symptoms from any of the following substances?

caffeine (coffee, pills, soft drinks, etc):Yes, alcohol:No

Regarding your alcohol or substance use, have you experienced any of the following (check all that apply)?

alcohol or substance is often taken in larger amounts or over a longer period of time than intended,there is a persistent desire or unsuccessful effort to cut down or control alcohol or substance use,a great deal of time is spent in activities necessary to obtain alcohol alcohol or substances, use these, or recover from its effects,craving, or a strong desire or urge to use alcohol or substances,recurrent alcohol or substance use resulting in a failure to fulfill major role obligations at work, school, or home,continued alcohol or substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol or substances,important social, occupational, or recreational activities are given up or reduced because of alcohol or substance use,recurrent alcohol or substance use in situations where it is physically dangerous,alcohol or substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol or substance,tolerance as defined by either of the following: a need for markedly increased amounts of alcohol to achieve intoxication or desired effect,a markedly diminished effect with continued use of the same amount of alcohol or substances,withdrawal as manifested by either of the following: the characteristic withdrawal syndrome for alcohol or substances,alcohol or substances (or a closely related substance, such as a benzodiazepine) is taken to relieve or avoid withdrawal symptoms

129. Have you ever enrolled in a substance recovery treatment program?

Yes

Did you complete this treatment program?

Yes

This treatment lasted from what date to what date?

From:

1993

To:

1994

Following this treatment you remained clean and sober for how long?

1 day

This clean and sober period lasted from when to when?

From:

1999-02-01

To:

1999-02-25

What is the longest that you have ever remained completely clean and sober from all alcohol and substance use?

1 month

When was this longest period of remaining clean and sober?

2021

While you were clean and sober, did you continue to experience any of your previously described psychiatric symptoms, such as depression and/or anxiety?

Yes

# Medical History

130. Have you been diagnosed by a healthcare provider with any of the following conditions?

arthritis,asthma,back problems,chronic pain,diabetes,heart Disease,hypertension,gastrointestinal problems,migraines,thyroid problems,other

131. Please list your general physical health medications, including your dosage for each medication:

lisinopril 20 mg per day

132. Have your general medical medications produced any side effects?

Lots of them

133. Have you ever had any surgeries?

Yes

Please list your previous surgeries with dates when possible.

elbow and foot in 2020

134. Do your treatment providers have any plans for your future medical care?

Yes

Please list your planned planned future medical care

PT and chiropractic for 6 months.

135. Your current primary care physician or nurse practitioner is (Name, Facility, City):

Dr. Don't call me

136. Past primary care physician or nurse practitioners (Name, Facility, City)?

Dr. Past Medical

During what time period did you receive this care from each provider?

1980-1990

137. List all of the hospitals you have ever been in for medical reasons (and when you were in this hospital):

General Medical Hospital 1999

138. Do you have any allergies or intolerances to medication or food?

Yes

Please list your intolerances or allergies.

Penicillin rash

# Family History

139. Do any of your family members suffer from the following psychiatric conditions?

depression,anxiety,bipolar Disorder

140. Have any of your family members attempted or committed suicide?

Yes

# Relationship History

141. Are you currently involved in an intimate relationship?

Yes

Are you currently married?

Yes

How long have you been involved in your current relationship?

10 years weeks

If yes, how would you describe your current intimate relationship?

stable,supportive,volatile,conflictual,about to end,other

What Is Your Spouse or Partner's Occupation?

bartender

Does your spouse or partner suffer from any general medical or psychiatric conditions (without naming their condition)?

Yes

Is your partner or spouse’s medical or psychiatric condition stressful for you?

Yes

142. How many times have you been married?

three

143. How many total long term intimate relationships have you had?

6

How long did each of your long term relationships last?

5 years, 2 years, 3 years

What are the reasons that your previous relationships/marriage ended?

move away, grew apart

Has there ever been domestic violence in any of your relationships?

Yes

144. Do you have children?

Yes

How many children do you have and what are their ages?

5

How are your children doing in school or work?

good

What is your relationship like with your children?

good

Do any of your children have any general or mental health issues?

Yes

# Employment History

145. What is your current employment status?

employed at less than 20 hours per week

What is the name of your employer?

Bail bonds

What is your employment title at this position?

Bondsman

What are your job duties?

give out bonds

Are you having any difficulty performing your job duties?

Yes

146. What is the name of your past employer immediately prior to any current job you may have?

|  |  |  |  |
| --- | --- | --- | --- |
| Employer (begin with your first job) | Your Job Title | Dates you started/left this Employment | Reason You Left This Job |
| Jones restaurant | cook | June 1980-July 1985 | better job |
| Paper company | paper distributor | 2000-2015 | higher pay |

147. Have you had any past workplace injuries?

Yes

When did this or these injuries occur?

2005

What as the nature of this injury or injuries?

sprain ankle

148. Have you ever submitted a Workers’ Compensation claim

Yes

149. Have you ever been placed on disability?

Yes

What were the dates of this disability?

2015

150. Have you ever received negative work evaluations, been terminated from a position, or received disciplinary action?

Yes

Please explain:

they said I'm bad at my job, 2005

151. List all of your current sources of income.

above employment,other employment,workers’ compensation benefits,spouses income,children’s income

# Education History

152. What is your highest level of education?

GED

153. What grades did you mostly receive during your education (choose all that apply)?

Bs,Cs

154. Were you ever identified as having a learning disability, or placed in any special education classes?

Yes

Please describe your learning difficulties?

can't read

155. Did you graduate high school?

Yes

Did you graduate on time?

No

156. Did you go to college

Yes

If so, did you complete your degree?

No

Name of college:

Smith college

College major or primary topic of study:

writing

# Social History

157. Are you experiencing any barriers to receiving healthcare?

Yes

Please select the barriers to healthcare you are experiencing:

financial constraint,unstable housing,transportation access,child-care,family disapproval,other

158. Please describe your current living situation(select all that apply):

owning own home,living with family,living with friends,living alone,temporary housing

159. Do you feel that you are in any danger at the present time?

Yes

Please describe the situation in which you feel in danger.

boss will attack me

160. List ALL stressors NOT related to work which happened in the past year (i.e., separation/divorce, death in family, problems with children, financial, foreclosure, bankruptcy, repossessions, etc).

my family left

Did these stressors affect your emotional symptoms

made me sad

How did each of these stressors affect your emotional symptoms?

Yes

161. Since Your Injury, Have You Experienced Any Other Stressors Besides Your Injury or Psychiatric Issue?

Yes

Please explain all of the stressors in your life?

no money

Did these stressors affect your emotional symptoms

Yes

How did each of these stressors affect your emotional symptoms?

stressed about money

162. Are you experiencing any other stressors in your life not covered above?

Yes

Explain:

want a better car

# Criminal History

163. Have you ever been arrested?

Yes

When were your arrests?

1995

What were the charges?

drugs

Were you ever incarcerated? If yes, for how long?

prison 10 years

Are you currently on parole or probation?

Yes

# Violence History

164. Have you ever been involved in physical altercations?

Yes

How many altercations have you been involved in?

20

What were the circumstances surrounding these altercations?

people disrespecting

165. Do you currently or have you recently had thoughts of wanting to hurt anyone?

Yes

Please explain who you want to hurt and how you may go about accomplishing this

kill my boss by stabbing

166. Have you ever been the victim of violence?

Yes

Are you currently in danger of violence?

Yes

# Military History

167. Have you ever enrolled in the military

Yes

Which branch of the military were you in?

coast Guard

What dates were you in the military?

from 1999-01-01 to 1999-12-01

What was your job in the military?

cook

What was your discharge status?

dishonorably(DD)

# CURRENT DAILY ACTIVITIES

168. What time do you wake up on work days?

5 am

169. What time do you wake up on non work days?

6 am

170. What time do you usually go to bed?

10 pm

171. What time do you usually fall asleep?

11 pm

172. Describe all of the activities you do from the time you wake up until you go to bed at night:

What you do from 6 a.m. to 8 a.m.:

sleep

What you do from 8 a.m. to 10 a.m.:

eat breakfast

What you do from 10 a.m. to 12 p.m.:

nothing

What you do from 12 p.m. to 2 p.m.:

walk

What you do from 2 p.m. to 4 p.m.:

nothing

What you do from 4 p.m. to 6 p.m.:

nap

What you do from 6 p.m. to 8 p.m.:

nothing

What you do from 8 p.m. to 10 p.m.:

work

What You Do From 10 p.m. to 12 p.m. (or time to bed):

go to bed

What you do from 12 p.m. to 6 a.m.:

sleep

173. What are your leisure activities or hobbies?

smoking

174. Do you have any trouble with the following?

Comprehending and following instructions: No, Performing simple and repetitive tasks: No, Maintaining a workplace appropriate to a given work load: Yes, Performing complex or varied tasks: No, Relating to other people beyond giving and receiving instructions: No, Making generalizations, evaluations or decisions without immediate supervision: Yes, Accepting and carrying out responsibility for direction, control, and planning: No

175. Activities of daily living worksheet. please put a mark in the box that describes your ability to carry out the following:

Bathing: Able to Do Independently, Dressing: Need Help, Grooming: Need Help, Oral Care: Can't Do, Toileting: Don't Do, Transferring: N/A, Walking: Can't Do, Cooking: Don't Do, Doing Dishes: Able to Do Independently, Eating: Able to Do Independently, Shopping: Need Help, Managing Medications: Don't Do, Using the Phone: Can't Do, Housework: N/A, Doing Laundry: Able to Do Independently, Driving: Need Help, Managing Finances: Able to Do Independently, Recreation: Don't Do

176. Please rate the amount of difficulty you have with the following:

Concentrating: No Difficulty, Listening: Some Difficulty, Reading: Much Difficulty, Studying: Much Difficulty, Writing: Unable to Do

177. Please list any activities not included above that you used to do but are unable to do or don't do because of your condition and explain why

smoking

# Developmental History

178. Where were you born?

Memphis, TN

179. Where were you primarily raised?

Sacramento

180. Who primarlily raised you during your childhood?

biological mother and father

Please describe your relationship with the person who primarily raised you during your childhood:

fair

181. How would you rate your relationship with the primary adults who raised you when you were a child?

positive(stable, supportive, or loving),medium(some disruption in the relationship, some level of conflicts)

182. Do you have siblings?

Yes

How many siblings do you have?

7

How many of these siblings were you raised with?

3

How is your relationship with your siblings (select all that apply)?

medium (some disruption in the relationship, some level of conflicts)

183. Did you experience any abuse during your childhood?

physical abuse

184. Were your parents ever married?

Yes

Did your parents remain married?

Yes

185. Did your mother work?

Yes

What was her job?

doctor

Does your mother still work?

Yes

186. Is your mother current living?

Memphis, TN

How old was she when she died?

55

What did she die from?

working too much

187. Did your father work?

Yes

What was his job?

janitor

Does your father still work?

Yes

188. Is your father current living?

Yes

189. Which of these statements best describes your social life as a child:

I prefered to spend time alone and had few friends

190. What activities did you enjoy during your childhood?

baseball

# Additional Information

191. Is there anything else you would like to share with the evaluating clinician before your visit begins?

Give me disability money

192. Please provide any other additional information not already covered above

Nice intake form