

# Johnson Neuropsychology, PLLC

## Parent Questionnaire 4-17 yrs

Please answer the following questions carefully and completely. Your answers will help us greatly in our understanding of your child. The questionnaire will be reviewed with you, so it will be possible to discuss your answers if you wish.

CHILD'S NAME: \_\_\_\_\_ DATE: \_\_\_\_\_  
 NICKNAME: \_\_\_\_\_ AGE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_  
 GENDER(Circle one): Male Female POUNOUNS: \_\_\_\_\_ ETHNICITY: \_\_\_\_\_  
 HANDEDNESS (CIRCLE ONE): RIGHT LEFT AMBIDEXTROUS  
 NAME OF LEGAL GUARDIANS: \_\_\_\_\_  
 PERSON COMPLETING FORM: \_\_\_\_\_ RELATION TO CHILD: \_\_\_\_\_  
 HOW WERE YOU REFERRED? \_\_\_\_\_

### **PROBLEMS AND CONCERNS**

Please list, in order of urgency, the problem(s) for which you are seeking help for your child (Use back of sheet if necessary):

- A. \_\_\_\_\_
- B. \_\_\_\_\_
- C. \_\_\_\_\_
- D. \_\_\_\_\_
- E. \_\_\_\_\_
- F. \_\_\_\_\_
- G. \_\_\_\_\_
- H. \_\_\_\_\_

### **FAMILY HISTORY**

#### **1. Who is this child currently living with? (check all that apply)**

- both natural parents     stepmother     adoptive parents
- natural mother     stepfather     grandparent *circle*: grandmother, grandfather / mother's side, father's side
- natural father     foster parents     other (describe) \_\_\_\_\_

#### **2. Parental information**

	Mother	Father
<u>Occupation:</u>		
<u>Age:</u>		
<u>Highest grade completed:</u>		

**3. . List all people living in the child's home?**

Name

Age

Relation to child

---



---



---



---

**4. What languages are spoken in the home? What languages does your child speak, and how proficient are they? What was your child's first language?**

---



---

**5. Please describe the current marital status/custody information.**

---



---



---

**6. Please list the important events or changes that have occurred in your child's lifetime (for example: deaths, marital separations, divorces, remarriages, family moves, loss of important friendships, serious illnesses, financial problems, parental conflict, family violence, etc.). List any other events which, in your opinion, have had important meaning or significant impact on your child or your family. If you are uncertain about the significance, please list it anyway. Please provide specific dates during which each event occurred and identify the persons involved.**

Dates or ages

Changes

---



---



---

**PREGNANCY**

1. Was the pregnancy (*check all that apply*): planned unplanned wanted unwanted with prenatal care  
without prenatal care

2. Age of parents at time of child's birth: \_\_\_\_\_mother \_\_\_\_\_father

**3. While mother was pregnant, did she have any of the following difficulties?**

Chronic Disease: Yes No \_\_\_\_\_

Accidents/Injuries: Yes No \_\_\_\_\_

Surgeries: Yes No \_\_\_\_\_

Medications: Yes No \_\_\_\_\_

Alcohol Intake: Yes No \_\_\_\_\_

Drug Use: Yes No \_\_\_\_\_

Smoke Cigarettes: Yes No \_\_\_\_\_

Exposure To Toxic Chemicals Or Substances: Yes No \_\_\_\_\_

Stressful Events For One Or Both Parents: Yes No \_\_\_\_\_

**DELIVERY**

1. How long did labor last: \_\_\_\_\_ 2. Baby's weight at birth: \_\_\_\_\_

3. Was baby full term? \_\_\_\_\_ If not, how many weeks premature? \_\_\_\_\_

4. Length of hospital stay for mother? \_\_\_\_\_ Length of stay for child? \_\_\_\_\_

**5. Were any of the following present during or soon after delivery? (check all that apply)**

- mother was put to sleep
- C Section performed
- Instruments used to deliver
- Rh factor present
- breech birth or presentation
- born with cord around neck
- baby was blue
- baby was placed in an incubator. For how long? \_\_\_\_\_
- other medical problems at birth (describe): \_\_\_\_\_
- baby was jaundiced (yellow)
- baby aspirated meconium (breathed waste)
- baby needed blood
- baby needed oxygen
- baby had trouble sucking
- baby had trouble keeping food down

**DEVELOPMENTAL HISTORY:**

**1. Did any of the following occur during infancy? (check all that apply)**

- baby had problems sleeping \_\_\_\_\_
- baby was frequently fussy or colicky \_\_\_\_\_
- baby had unusual crying \_\_\_\_\_
- baby had trouble breathing \_\_\_\_\_
- baby had problems eating or gaining weight \_\_\_\_\_
- baby experienced convulsions, seizures, or “staring spells” \_\_\_\_\_
- baby had excessive diarrhea or dehydration \_\_\_\_\_
- mother was depressed, anxious, or unusually stressed \_\_\_\_\_
- mother was physically ill or injured \_\_\_\_\_

**2. Who was primarily responsible of baby’s caretaking?** \_\_\_\_\_  
 Who assisted in the baby’s care? \_\_\_\_\_

**3. During your child’s first year of life, was there anything (even if it had nothing to do with the baby) that caused unhappiness in the family, or placed the mother or father under special strain?**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**4. Did mother (or primary caretaker) work before this child entered school?** \_\_\_\_yes \_\_\_\_no

If yes, who cared for this child while the mother worked?

- babysitter
- family member: \_\_\_\_\_
- day care center(s)

**5. How do you feel your child developed in the following areas?**

- Physical & Motor Development  faster than average  average  slower than average
- Talking & Language Development  faster than average  average  slower than average
- Relationships and Social Development  faster than average  average  slower than average

<u>Developmental Skill</u>	<u>Approximate Age</u>
Crawled	
Walked	
Spoke first words	
Spoke simple phrases	
Spoke in sentences	
Followed simple instructions	
Toilet trained, day	
Toilet trained, night	

**6. Did your child have any problems in the following areas?**

- |                                          |                                                          |                          |                                                          |
|------------------------------------------|----------------------------------------------------------|--------------------------|----------------------------------------------------------|
| Learning the names of colors and shapes  | <input type="checkbox"/> No <input type="checkbox"/> Yes | Cutting with scissors    | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Learning to riding a 2-wheeled bicycle   | <input type="checkbox"/> No <input type="checkbox"/> Yes | Learning to tell time    | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Learning to climb stairs, hop, or skip   | <input type="checkbox"/> No <input type="checkbox"/> Yes | Learning to tie shoes    | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Learning to use zippers or buttons       | <input type="checkbox"/> No <input type="checkbox"/> Yes | Separating from parents  | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Giving appropriate eye contact           | <input type="checkbox"/> No <input type="checkbox"/> Yes | Making friends           | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Learning the names or sounds of letters  | <input type="checkbox"/> No <input type="checkbox"/> Yes | Learning to read         | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Learning how to write letters or numbers | <input type="checkbox"/> No <input type="checkbox"/> Yes | Learning to count or add | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Learning right and left                  | <input type="checkbox"/> No <input type="checkbox"/> Yes | Reciting the alphabet    | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Understanding jokes                      | <input type="checkbox"/> No <input type="checkbox"/> Yes | Adjusting to change      | <input type="checkbox"/> No <input type="checkbox"/> Yes |

**7. Describe anything else hard for him/her to learn or master:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**8. Did family, friends, etc. ever have difficulty understanding his/her speech?**  No  Yes:

**MEDICAL HISTORY**

**1. Please give details of any medical problems, procedures, surgeries, or prior hospitalizations for your child (Use back of sheet if necessary).**

<u>Type</u>	<u>Age</u>
_____	_____
_____	_____
_____	_____
_____	_____

**2. Please write the ages (in years) that your child had any of the following illnesses:**

<u>Ages</u>	<u>Ages</u>	<u>Ages</u>
_____ Allergies	_____ Frequent Ear Infections	_____ Menstrual Problems
_____ Asthma	_____ Frequent Stomachaches	_____ Oxygen Deprivation
_____ Blood Transfusion	_____ Head Injuries/Concussion	_____ or Near drowning
_____ Convulsions/ Seizures	_____ Headaches	_____ Pneumonia
_____ Diabetes	_____ Heart Trouble	_____ Prolonged Colic
_____ Fainting	_____ High Fever	_____ Tonsillitis
_____ Frequent Colds/Sore	_____ Infections (Meningitis, Encephalitis)	_____ Tics, Twitching
Throats		
_____ Frequent Ear Aches	_____ Major Fractures	Other: _____

**3. My child's present medications and/or supplements are:**

<u>Medication</u>	<u>Dosage</u>	<u>Frequency</u>	<u>Helpful?</u>	<u>Date Started</u>	<u>Side Effects?</u>
			Y/N/DK		
			Y/N/DK		
			Y/N/DK		
			Y/N/DK		
			Y/N/DK		
			Y/N/DK		

**4. Has your child ever taken medication for ADHD that resulted in no improvement or worse behavior? Describe:**  
 \_\_\_\_\_  
 \_\_\_\_\_

**5. Vision and hearing:**

Vision (circle):      Normal    Corrected    Needs to be checked  
 Hearing (circle):      Normal    Corrected    Needs to be checked

**6. Please describe your child’s eating habits. Note any problems in this area.**

---



---

**7. Please describe your child’s sleeping habits. (circle all that apply):**

sleepwalking      nightmares      recurrent dreams      sleeps with light on      difficulty falling asleep  
 wakes up during the night      difficulty getting up      must sleep with another person

Does your child’s legs jump often or does he/she kick the blankets off at night? Yes/No

Does your child snore? Yes/ No If yes: a. Is your child overweight? Yes/No

Does your child have periods that he/she stops breathing while sleeping Yes/No

**8. Any Family History (immediate & extended [close relatives]) of:**

	YES	NO	Which Family Member(s)?
Learning Problems	_____	_____	_____
Depression	_____	_____	_____
ADD / ADHD	_____	_____	_____
Hyperactivity	_____	_____	_____
Problems paying attention	_____	_____	_____
Dyslexia	_____	_____	_____
Mental Retardation	_____	_____	_____
Speech/Language Disorders	_____	_____	_____
Autism / Asperger’s / PDD	_____	_____	_____
Seizures	_____	_____	_____
Emotional problems	_____	_____	_____
Depression	_____	_____	_____
Extreme nervousness	_____	_____	_____
Explosive temper	_____	_____	_____
Convulsions or seizures	_____	_____	_____
Extreme shyness	_____	_____	_____
Drinking problem/alcoholism	_____	_____	_____
Drug problem/addiction	_____	_____	_____
Victim of abuse	_____	_____	_____
Sexual abuser	_____	_____	_____
Victim of sexual abuse	_____	_____	_____
Sleep problems	_____	_____	_____
Bipolar Disorder (manic depression)	_____	_____	_____
Anxiety	_____	_____	_____
Left-handedness or mixed-handedness	_____	_____	_____
Other (Please Explain):	_____	_____	_____

**9. Has your child ever received counseling or testing for mental health or learning problems? Yes or No**

---



---



---



---

**SCHOOL HISTORY**

1. Current grade: \_\_\_\_\_ Current school: \_\_\_\_\_

2. Did your child attend day care? Yes No How old was your child when s/he started? \_\_\_\_\_  
 If yes, describe the setting and the child's reaction to it? \_\_\_\_\_

3. Has your child received Early Intervention Services (e.g. Head Start or PPCD)? Yes No  
 If yes, age at start of services? \_\_\_\_\_ How often? \_\_\_\_\_ When did services end? \_\_\_\_\_  
 Services received: (Circle all that apply): Speech/Language Physical Therapy Occupational Therapy  
 Other: \_\_\_\_\_

4. Has your child ever repeated a grade? Yes No If yes, what grade and what was the reason?  
 \_\_\_\_\_

5. Is your child currently undergoing or in the process of receiving an initial evaluation or re-evaluation for special education? Yes No  
 If yes, please reach out to the office directly for more information.

6. Does your child have or have they ever had an Individualized Education Program (IEP)? Yes No  
 If yes, please attach a copy of your child's IEP and most recent school testing (Full Individual Evaluation).  
 At what age/grade did they first get an IEP? \_\_\_\_\_  
 Was it ever discontinued? Yes No  
 If yes, when and why? \_\_\_\_\_  
 Are you happy with the services your child receives? Yes No

Please indicate if your child may have received any of the following services in *school*.  
 \_\_\_\_\_ Speech Therapy \_\_\_\_\_ Physical Therapy \_\_\_\_\_ Occupational Therapy  
 \_\_\_\_\_ Resource Room \_\_\_\_\_ Content Mastery \_\_\_\_\_ Special Education

Special Education Qualification: (*mark all that apply*)  
 MR  LD  OHI  TBI  VI  SI  OI  ED

7. Does your child have a 504 Accommodation Plan? Yes No  
 If yes, please attach a copy of your child's current plan and any school testing.

8. Does your child receive any informal support, accommodations, or help at school? Yes No  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

9. Please rate your child's current school performance (for children ages 6 and older):

Subject	Failing	Below Average	Average	Above Average
Reading or English				
Writing				
Math				
Spelling				
Sciences				
Other:				

10. Are there any BEHAVIOR PROBLEMS in school? Yes No  
 Suspensions or expulsions? Yes No

---



---



---

11. School homework for this child: (check all that apply)

- Is something s/he enjoys doing. \_\_\_\_\_
- Is a source of unhappiness and trouble. \_\_\_\_\_
- Is something s/he has to be forced to do. \_\_\_\_\_

12. Your child usually studies:

Where? \_\_\_\_\_  
 When? \_\_\_\_\_  
 How long? \_\_\_\_\_

**DISCIPLINE**

1. Would you describe this child as obedient, or compliant with requests? \_\_\_\_\_

2. This child is disciplined by (check all that apply):

- mother
- father
- brother/sister
- other: \_\_\_\_\_

3. Discipline most often used (in order of frequency): \_\_\_\_\_

4. Discipline that is most effective with this child: \_\_\_\_\_

5. Describe how this child reacts to punishment: \_\_\_\_\_

6. Has your child ever been arrested? Yes No \_\_\_\_\_

**SOCIAL AND EMOTIONAL FUNCTIONING**

1. Describe this child's friendships: A leader or follower? Older or younger friends?

---

2. Any problems in friendships (teasing, aggressiveness, rejection, etc.)? \_\_\_\_\_

3. How does this child show affection? \_\_\_\_\_

4. Is it hard for this child to trust other people? \_\_\_\_\_ Does he/she feel comfortable around others? \_\_\_\_\_

5. Compared to other children of your child's age, how well does your child...

	Worse	Same	Better	Comments
Get along with brothers/sisters				
Get along with other children				
Play/work by self				
Behave in public (restaurants, etc.)				
Behave with baby-sitters				
Behave at daycare/school				

6. How often per week does this child feel really angry? What makes him/her feel that way? What does he/she do?

---



---

7. Is this child a worrier? \_\_\_\_\_ What types of types of things does he/she worry about? \_\_\_\_\_
8. Describe any nervous habits (nail biting, thumb sucking, hair pulling, etc.) \_\_\_\_\_
9. Compared to other children of your child's age, how well does your child...

	Worse	Same	Better	Comments
Get along with brothers/sisters				
Get along with other children				
Play/work by self				
Behave in public (restaurants, etc.)				
Behave with baby-sitters				
Behave at daycare/school				

10. How often per week does this child feel really angry? What makes him/her feel that way? What does he/she do? \_\_\_\_\_
11. Is this child a worrier? \_\_\_\_\_ What types of types of things does he/she worry about? \_\_\_\_\_
12. Describe any nervous habits (nail biting, thumb sucking, hair pulling, etc.) \_\_\_\_\_
13. Describe any unusual or problem behaviors not described above: \_\_\_\_\_

**ACTIVITIES OF DAILY LIVING:**

How does the child like to spend his/her time? \_\_\_\_\_

What kinds of things does this child enjoy? \_\_\_\_\_

List current extracurricular activities: \_\_\_\_\_

Please describe electronic/TV use at home: \_\_\_\_\_

What household chores is he/she responsible for? \_\_\_\_\_

- How does he/she complete them? **Check all that apply**     Independently     With One Reminder  
 With Several Reminders     With Assistance     Only After Being Disciplined Or Threatened With Discipline



**ALCOHOL AND/OR DRUG USE:** *It is important that the minor help complete this section completely and honestly.*

HAS THE MINOR EVER USED...	(Circle one)	Age minor began using	Is the minor currently using?	When did the minor last use?	How much does the minor use (or did use in the past)?
		Yes No	Yes No		
Alcohol (beer, wine, mixed drinks).....	Yes No		Yes No		
Marijuana.....	Yes No		Yes No		
Amphetamines, Meth.: <input type="checkbox"/> oral, <input type="checkbox"/> nasal, <input type="checkbox"/> IV, <input type="checkbox"/> smoke.....	Yes No		Yes No		
Cocaine: <input type="checkbox"/> nasal or <input type="checkbox"/> IV.....	Yes No		Yes No		
Prescription medication in an abusive manner.....	Yes No		Yes No		
Heroin.....	Yes No		Yes No		
Opiates (morphine, codeine, Demerol).....	Yes No		Yes No		
Hallucinogens, PCP.....	Yes No		Yes No		
Inhalants (glue, gas, spray).....	Yes No		Yes No		
Nicotine.....	Yes No		Yes No		
Other:	Yes No		Yes No		

**Previous Alcohol or Substance Abuse Treatment History:**

Where	Year	Type Inpatient or Outpatient	Days/Months in treatment	Completed Program?	How long has the minor been sober/clean? (If applicable)
				Y N	
				Y N	

Please feel free to add additional comments:

# Amen Child/Teen Brain System Checklist

Copyright 1997 Daniel G. Amen, MD

Please rate your child/teen on each of the symptoms listed below using the following scale. If practical and/or possible, to give us the most complete picture, have your child rate him/herself first in the first column (CH/TN) Please list who completed this form. \_\_\_\_\_

0	1	2	3	4	NA
Never	Rarely	Occasionally	Frequently	Very Frequently	Not Applicable/Not Known

CH/TN Parent

- |       |       |                                                                                                    |
|-------|-------|----------------------------------------------------------------------------------------------------|
| _____ | _____ | 1. Failing to give close attention to details or making careless mistakes                          |
| _____ | _____ | 2. Having trouble sustaining attention in routine situations (e.g., homework, chores, paperwork)   |
| _____ | _____ | 3. Having trouble listening                                                                        |
| _____ | _____ | 4. Failing to finish things                                                                        |
| _____ | _____ | 5. Having poor organization for time or space (such as a backpack, room, desk, paperwork)          |
| _____ | _____ | 6. Avoiding, disliking, or being reluctant to engage in tasks that require sustained mental effort |
| _____ | _____ | 7. Losing things                                                                                   |
| _____ | _____ | 8. Being easily distracted                                                                         |
| _____ | _____ | 9. Being forgetful                                                                                 |
| _____ | _____ | 10. Having poor planning skills                                                                    |
| _____ | _____ | 11. Lacking clear goals or forward thinking                                                        |
| _____ | _____ | 12. Having difficulty expressing feelings                                                          |
| _____ | _____ | 13. Having difficulty expressing empathy for others                                                |
| _____ | _____ | 14. Experiencing excessive daydreaming                                                             |
| _____ | _____ | 15. Feeling bored                                                                                  |
| _____ | _____ | 16. Feeling apathetic or unmotivated                                                               |
| _____ | _____ | 17. Feeling tired, sluggish or slow moving                                                         |
| _____ | _____ | 18. Feeling spacey or "in a fog"                                                                   |
| _____ | _____ | 19. Feeling fidgety, restless or trouble sitting still                                             |
| _____ | _____ | 20. Having difficulty remaining seated in situations where remaining seated is expected            |
| _____ | _____ | 21. Running about or climbing excessively in situations in which it is inappropriate               |
| _____ | _____ | 22. Having difficulty playing quietly                                                              |
| _____ | _____ | 23. Being always "on the go" or acting as if "driven by a motor"                                   |
| _____ | _____ | 24. Talking excessively                                                                            |
| _____ | _____ | 25. Blurting out answers before questions have been completed                                      |
| _____ | _____ | 26. Having difficulty waiting for turn                                                             |
| _____ | _____ | 27. Interrupting or intruding on others (e.g., butting into conversations or games)                |
| _____ | _____ | 28. Behaving impulsively (saying or doing things without thinking first)                           |
| _____ | _____ | 29. Worrying excessively or senselessly                                                            |
| _____ | _____ | 30. Getting upset when things do not go your way                                                   |
| _____ | _____ | 31. Getting upset when things are out of place                                                     |
| _____ | _____ | 32. Tending to be oppositional or argumentative                                                    |
| _____ | _____ | 33. Tending to have repetitive negative thoughts                                                   |
| _____ | _____ | 34. Tending toward compulsive behaviors (i.e., things you feel you <i>must</i> do)                 |
| _____ | _____ | 35. Intensely disliking change                                                                     |
| _____ | _____ | 36. Tending to hold grudges                                                                        |
| _____ | _____ | 37. Having trouble shifting attention from subject to subject                                      |
| _____ | _____ | 38. Having trouble shifting behavior from task to task                                             |
| _____ | _____ | 39. Having difficulties seeing options in situations                                               |
| _____ | _____ | 40. Tending to hold on to own opinion and not listen to others                                     |
| _____ | _____ | 41. Tending to get locked into a course of action, whether or not it is good                       |
| _____ | _____ | 42. Needing to have things done a certain way or else becoming very upset                          |
| _____ | _____ | 43. Others complaining that you worry too much                                                     |
| _____ | _____ | 44. Tending to say no without first thinking about the question                                    |

- \_\_\_ 45. Tending to predict fear
- \_\_\_ 46. Experiencing frequent feelings of sadness
- \_\_\_ 47. Having feelings of moodiness
- \_\_\_ 48. Having feelings of negativity
- \_\_\_ 49. Having low energy
- \_\_\_ 50. Being irritable
- \_\_\_ 51. Having a decreased interest in other people
- \_\_\_ 52. Having a decreased interest in things that are usually fun or pleasurable
- \_\_\_ 53. Having feelings of hopelessness about the future
- \_\_\_ 54. Having feelings of helplessness or powerlessness
- \_\_\_ 55. Feeling dissatisfied or bored
- \_\_\_ 56. Feeling excessive guilt
- \_\_\_ 57. Having suicidal feelings
- \_\_\_ 58. Having crying spells
- \_\_\_ 59. Having lowered interest in things that are usually considered fun
- \_\_\_ 60. Experiencing sleep changes (too much or too little)
- \_\_\_ 61. Experiencing appetite changes (too much or too little)
- \_\_\_ 62. Having chronic low self-esteem
- \_\_\_ 63. Having a negative sensitivity to smells/odors
- \_\_\_ 64. Frequently feeling nervous or anxious
- \_\_\_ 65. Experiencing panic attacks
- \_\_\_ 66. Symptoms of heightened muscle tension (such as headaches, sore muscles, hand tremors, etc.)
- \_\_\_ 67. Experiencing periods of a pounding heart, a rapid heart rate, or chest pain
- \_\_\_ 68. Experiencing periods of troubled breathing or feeling smothered
- \_\_\_ 69. Experiencing periods of dizziness, faintness, or feeling unsteady on your feet
- \_\_\_ 70. Feeling nausea or having an upset stomach
- \_\_\_ 71. Experiencing periods of sweating, hot flashes, or cold flashes
- \_\_\_ 72. Tending to predict the worst
- \_\_\_ 73. Having a fear of dying or doing something crazy
- \_\_\_ 74. Avoiding places for fear of having an anxiety attack
- \_\_\_ 75. Avoiding conflict
- \_\_\_ 76. Excessively fearing being judged or scrutinized by others
- \_\_\_ 77. Having persistent phobias
- \_\_\_ 78. Having low motivation
- \_\_\_ 79. Having excessive motivation
- \_\_\_ 80. Experiencing tics (either motor or vocal)
- \_\_\_ 81. Having poor handwriting
- \_\_\_ 82. Being quick to startle
- \_\_\_ 83. Having a tendency to freeze in anxiety-provoking situations
- \_\_\_ 84. Lacking confidence in own abilities
- \_\_\_ 85. Feeling shy or timid
- \_\_\_ 86. Being easily embarrassed
- \_\_\_ 87. Being sensitive to criticism
- \_\_\_ 88. Biting fingernails or picking at skin
- \_\_\_ 89. Having a short fuse or experiencing periods of extreme irritability
- \_\_\_ 90. Having periods of rage with little provocation
- \_\_\_ 91. Often misinterpreting comments as negative when they are not
- \_\_\_ 92. Finding that own irritability tends to build, then explodes, then recedes, often being tired after a rage
- \_\_\_ 93. Having periods of spaciness and/or confusion
- \_\_\_ 94. Experiencing periods of panic and/or fear for no specific reason
- \_\_\_ 95. Complains of hearing things or seeing things that no one else sees or hears
- \_\_\_ 96. Having frequent periods of *deja vu* (that is, feelings of having already been somewhere you've never been)
- \_\_\_ 97. Being sensitive or mildly paranoid
- \_\_\_ 98. Experiencing headaches or abdominal pain of uncertain origin
- \_\_\_ 99. Having a history of a head injury or family history of violence or explosiveness
- \_\_\_ 100. Having dark thoughts, ones that may involve suicidal or homicidal thoughts
- \_\_\_ 101. Experiencing periods of forgetfulness or memory problems