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July 31, 2009

Jack Hill, Esq.
Searcy Denney Scarola Barnhart &
Shipley, P.A
2139 Palm Beach Lakes Blvd.
West Palm Beach, FL 33409

Re: **CMA v. Epstein**

Dear Jack:

Please find enclosed questionnaires for your client to fill out in advance of the IME appointment set for August 20, 2009 at 9:00 a.m. at my firm. My expert, Ryan C. W. Hall, M.D., respectfully requests that your client fill these out and send them back to me within one week.

I look forward to your cooperation in this matter.

Very truly yours,

Michael J. Pike

cc: Jack A. Goldberger, Esq.
Robert D. Critton, Jr.

EXHIBIT
1

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LIFE HISTORY QUESTIONNAIRE
RELEASE OF INFORMATION

I hereby give permission to Dr. Richard C. W. Hall/Dr. Ryan C. W. Hall to use the information I gave in the Life History Questionnaire. I understand that this consent is revocable upon written notice to Dr. Hall, except to the extent that action by him has been taken in reliance on this authorization.

NAME _____ Date_____

WITNESS _____ Date_____

CASE NO. _____

LIFE HISTORY QUESTIONNAIRE

Name _____

The purpose of this questionnaire is to help us to better understand you and the problems which brought you to our office. Since some of the information you will be giving us in this questionnaire is of a personal nature, we want to assure you that all case records are held in strict confidence. Unless required by law, your case record will not be released without your permission. Findings from this questionnaire may be used in compiling group data and will never be released in any way that could identify you.

Please read the questions carefully and answer as accurately as you can. The questionnaire will probably take about fifteen minutes to complete, but feel comfortable working at your own pace.

EARLY DEVELOPMENT

Date of birth _____ Age _____

1. As a child did you have any of the following?

   Serious Accidents ☐ No ☐ Yes, please specify _____

   _____

   Serious Illnesses ☐ No ☐ Yes, please specify _____

   _____

   Surgeries ☐ No ☐ Yes, please specify _____

   _____

2. Did either parent die during your childhood or adolescence?

   ☐ No

   ☐ Yes, my mother, when I was _____ years old.

   ☐ Yes, my father, when I was _____ years old.

   ☐ Unknown

3. Check the persons with whom you lived most of the time while growing up.

   ☐ Both my natural parents

   ☐ One parent and ☐ stepmother or ☐ stepfather

   ☐ One parent, ☐ mother or ☐ father

   ☐ Other relative (explain) _____

   ☐ Foster parent(s)

   ☐ Adoptive parent(s)

   ☐ An Institution

   ☐ Other (explain) _____

4. Were you able to confide in your parents?

   ☐ Yes, usually ☐ No, not usually ☐ Not applicable

5. How well did your parents get along with each other?

   ☐ Very well ☐ Not very well ☐ Don't know

   ☐ Fairly well ☐ Very poorly ☐ Not applicable

643-0010 (10-92)dlh(MPC#351)

Check any of the following that you know have applied to your parents or brothers or sisters.
Specify family member below

- ☐ Hospitalization for mental illness _____
- ☐ Drinking problem _____
- ☐ Drug abuse _____
- ☐ Attempted or committed suicide _____
- ☐ Don't know _____

7. How many schools did you attend from grades 1 through 12?
   ☐ 1 - 3 ☐ 4 - 7 ☐ More than 7 ☐ Don't know
8. What kind of grades did you make in school? ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Failing
9. Did you participate in school activities? ☐ No ☐ Yes, some ☐ Yes, many
10. When you were growing up, did you belong to church(es), club(s) or other organized group(s)?
    ☐ Yes, many ☐ Yes, a few ☐ None
11. Did you have close friends around your own age? ☐ Many ☐ Few ☐ One ☐ None
12. Check any of the following that applied to you as a child.

☐ nightmares	☐ stealing	☐ fire setting
☐ nail biting	☐ running away	☐ accident prone
☐ speech problems	☐ bullying	☐ lying
☐ daydreaming	☐ sleepwalking	☐ temper tantrums
☐ cruelty to animals	☐ bed wetting	☐ loneliness
☐ scapegoat (picked on)	☐ thumb sucking	☐ insomnia
☐ head banging		

13. How would you describe your physical health at present?
    ☐ Excellent ☐ Good ☐ Fair ☐ Poor
14. Have you ever had any of the following?

Yes		Do you still have a problem with this? Yes
☐	heart trouble	☐
☐	nervous breakdown	☐
☐	epilepsy	☐
☐	tuberculosis	☐
☐	diabetes	☐
☐	teeth trouble	☐
☐	eye trouble	☐
☐	nose trouble	☐
☐	bladder trouble	☐
☐	kidney trouble	☐
☐	bowel trouble	☐
☐	stomach trouble	☐
☐	chest trouble	☐

Yes		Do you still have a problem with this? Yes
☐	backache	☐
☐	hernia	☐
☐	dizziness	☐
☐	blackout	☐
☐	rheumatism	☐
☐	chronic cough	☐
☐	shortness of breath	☐
☐	fits or convulsions	☐
☐	cancer	☐
☐	asthma	☐
☐	arthritis	☐
☐	high blood pressure	☐
☐	low blood pressure	☐

Yes		Do you still have a problem with this? Yes
☐	hemorrhoids (piles)	☐
☐	jaundice	☐
☐	hay fever	☐
☐	other allergy	☐
☐	venereal disease	☐
☐	ulcers	☐
☐	blood in urine	☐
☐	sugar in urine	☐
☐	varicose veins	☐
☐	underweight problem	☐
☐	overweight problem	☐
☐	injury to limb(s)	☐
☐	injury to back	☐
☐	injury to neck	☐

15. Have you ever had a problem with any of the following?

- ☐ Pep pills, diet pills
- ☐ Tranquilizers, sedatives
- ☐ Marijuana
- ☐ Narcotics
- ☐ Alcohol
- ☐ LSD, or other hallucinogen (exclude marijuana)
- ☐ Other, please specify _____
- ☐ No

16. With whom are you living at present?

- ☐ Spouse, or spouse and child(ren)
- ☐ Parent(s)
- ☐ Minor child(ren)
- ☐ Grown child(ren)
- ☐ Other relative(s)
- ☐ Friend(s)
- ☐ Alone
- ☐ Other, explain _____

17. Check the statement which most closely describes how you are getting along with each of the following persons.

person	very well	fairly well	not very well	very poorly	uncertain	not applicable
Mother						
Father						
Sister(s)						
Brother(s)						
Spouse / Partner						
Female Child(ren)						
Male Child(ren)						

18. What is your present marital status?

- ☐ Single
- ☐ Living together, how long? _____
- ☐ Married, how long? _____
- ☐ Separated
- ☐ Divorced
- ☐ Widowed

643-0010 (10-92)dlh(MPC#351)

19.

	None OR a little of the time	Some of the time	Good part of the time	Most OR ALL of the time
I feel more nervous and anxious than usual				
I feel afraid for no reason at all				
I get upset easily or feel panicky				
I feel like I'm falling apart and going to pieces				
I feel that everything is all right and nothing bad will happen				
My arms and legs shake and tremble				
I am bothered by headaches, neck and back pain				
I feel weak and get tired easily				
I feel calm and can sit still easily				
I can feel my heart beating fast				
I am bothered by dizzy spells				
I have fainting spells or feel like it				
I can breath in and out easily				
I get feelings of numbness and tingling in my fingers and toes				
I am bothered by stomachaches or indigestion				
I have to empty my bladder often				
My hands are usually dry and warm				
My face gets hot and blushes				
I fall asleep easily and get a good night's rest				
I have nightmares				

20. Check any of the following that apply to you at the present time.

- ☐ hallucinating
- ☐ nightmares
- ☐ tense
- ☐ trusting
- ☐ easily hurt
- ☐ don't like vacations or weekends
- ☐ timid
- ☐ headaches
- ☐ calm
- ☐ depressed
- ☐ no appetite
- ☐ fainting spells
- ☐ friendly
- ☐ in conflict
- ☐ talented
- ☐ insomnia
- ☐ horrible thoughts
- ☐ thoughtful
- ☐ aggressive
- ☐ dizzy
- ☐ bad temper
- ☐ affectionate
- ☐ unloved
- ☐ modest
- ☐ well mannered
- ☐ rigid
- ☐ suicidal
- ☐ rejected
- ☐ flexible
- ☐ misunderstood
- ☐ too ambitious
- ☐ helpful
- ☐ bed wetting
- ☐ lonely
- ☐ evil
- ☐ stable
- ☐ inferior
- ☐ forgetful
- ☐ respected
- ☐ confused
- ☐ need help
- ☐ loyal
- ☐ tired
- ☐ unattractive
- ☐ cruel to animals
- ☐ unhappy
- ☐ daydreamer
- ☐ lack of confidence
- ☐ capable
- ☐ open
- ☐ guilty
- ☐ easily influenced
- ☐ unable to have a good time
- ☐ enthusiastic
- ☐ happy
- ☐ shy
- ☐ fire setter
- ☐ indecisive
- ☐ inadequate
- ☐ stupid
- ☐ worthless
- ☐ generous
- ☐ unable to concentrate
- ☐ bored
- ☐ restless
- ☐ lovable
- ☐ regretful
- ☐ panicky
- ☐ soft-hearted
- ☐ ugly
- ☐ agitated
- ☐ cowardly
- ☐ self-confident
- ☐ angry
- ☐ full of hate
- ☐ "can't do anything right"

643-0010 (10-92)dlh(MPC#351)

21. Check any of the following which describe your marriage or sexual partnership.

☐ Not applicable	☐ Friendly	☐ Poor sexual adjustment
☐ Stormy	☐ Lack of communication	☐ Mutual respect and love
☐ Happy	☐ Good sexual adjustment	☐ Perfect
☐ Insecure	☐ Indifferent	☐ Boring
☐ Average	☐ Mistake	☐ Secure
☐ Romantic	☐ Good communication	☐ Sharing of interest
☐ Exciting	☐ Lack of common interests	

22. How long did you know you present spouse before marriage? ☐ Not married _____ Year(s)

23. How many times have you been married? _____

24. How many close friends do you have. ☐ Many ☐ Few ☐ One ☐ None

25. Are you able to confide in these friends? ☐ No ☐ Yes ☐ Not applicable

26. How comfortable are you with:

	very comfortable	moderately comfortable	moderately uncomfortable	very uncomfortable
Joining a group				
Meeting people				
With persons of same sex				
With persons of opposite sex				
Being a leader				
Being a follower				
Expressing an unpopular opinion				
Being disliked				
Asking for help				
Taking advice				
Accepting criticism				
Competitive situations				
Taking initiative				

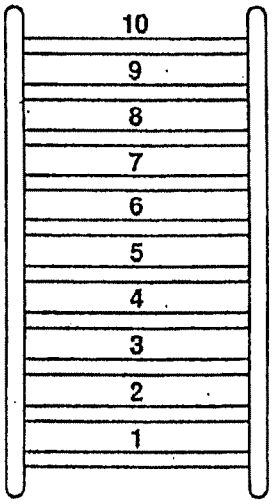
27. Does your present work satisfy you? ☐ Yes ☐ No ☐ Unemployed

28. Check any of the following which have been a problem for you.

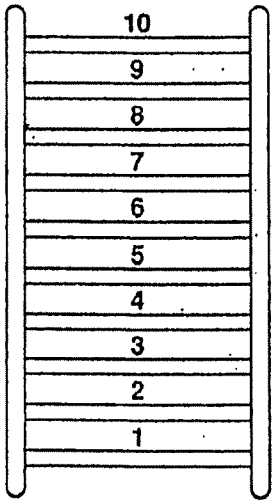
☐ Gambling	☐ Parents	☐ Sex	☐ Drinking
☐ Trouble with police	☐ Temper	☐ Marriage	☐ Drugs
☐ Men	☐ Violence	☐ Children	☐ Religion
☐ Women	☐ Friends	☐ Finances	☐ Job

643-0010 (10-92)dlh(MPC#351)

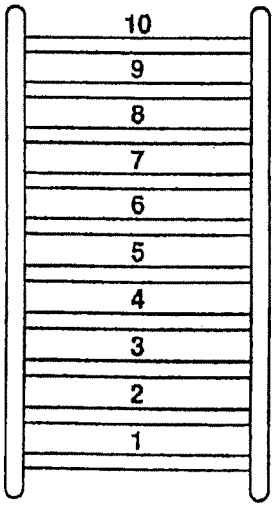
29. Here is a picture of a ladder. Suppose the top of the ladder represents the best possible life for you. Where on the ladder do you feel you stand at the present time? (Circle the correct number.)



30. Where on the ladder would you say you stood five years ago? (Circle number.)



31. Where on the ladder would you say you will stand five years from now? (Circle number.)



32. Check the most appropriate response.

	None or a little of the time	Some of the time	Good part of the time	Most or all of the time
1. I feel down-hearted and blue				
2. Morning is when I feel the best				
3. I have crying spells or feel like it				
4. I have trouble sleeping at night				
5. I eat as much as I used to				
6. I still enjoy sex				
7. I notice that I am losing weight				
8. I have trouble with constipation				
9. My heart beats faster than usual				
10. I get tired for no reason				
11. My mind is as clear as it used to be				
12. I find it easy to do the things I used to				
13. I am restless and can't keep still				
14. I feel hopeful about the future				
15. I am more irritable than usual				
16. I find it easy to make decisions				
17. I feel that I am useful and needed				
18. My life is pretty full				
19. I feel that others would be better off if I were dead				
20. I still enjoy the things I used to do				

33. Do you know anyone who has been treated by Dr. Hall?

☐ No ☐ Yes

34. If so, in your opinion, was the person(s) helped? (Check more than one, if applicable.)

☐ Yes, greatly ☐ No, not at all

☐ Yes, moderately ☐ No, became worse

☐ Only a little ☐ Not applicable

35. Do you think you need help? ☐ Yes ☐ No ☐ Don't know

36. Do others think you need help? ☐ Yes ☐ No ☐ Don't know

37. How long do you think you should be in treatment?

☐ Less than 1 month ☐ More than 1 year

☐ More than 1 month, less than 6 months ☐ Don't know

☐ More than 6 months, less than 1 year

643-0010 (10-92)dlh(MPC#351)

PATIENT INFORMATION DATA BASE

NAME: _____

AGE: _____ DATE: _____

PREVIOUS PHYSICIAN (NAME AND ADDRESS): _____

PAST MEDICAL HISTORY (PLEASE CHECK ALL ITEMS TO THE BEST OF YOUR KNOWLEDGE):

Yes	No	
☐	☐	Hypertension _____
☐	☐	Arthritis _____
☐	☐	Diabetes _____
☐	☐	Tuberculosis _____
☐	☐	Pneumonia _____
☐	☐	Venereal Disease _____
☐	☐	Thyroid Disease, Goiter _____
☐	☐	High Cholesterol or Triglycerides _____
☐	☐	Asthma, Hay Fever _____
☐	☐	Emphysema _____
☐	☐	Bronchitis _____
☐	☐	Recurrent Sinusitis _____
☐	☐	Skin Disease (Eczema, Psoriasis, Cancer, etc.) _____
☐	☐	Heart Attack _____
☐	☐	Abnormal Heart Beat _____
☐	☐	Heart Failure _____
☐	☐	Rheumatic Fever _____
☐	☐	Heart Murmur _____
☐	☐	Congenital Heart Disease _____
☐	☐	Breast Lumps _____
☐	☐	Blood Disorders _____
☐	☐	Leukemia, Lymphoma _____
☐	☐	Anemia _____
☐	☐	Peptic Ulcer _____
☐	☐	Gall Bladder problems _____
☐	☐	Bowel Disorders (Colitis, Spastic Colon, etc.) _____
☐	☐	Hernia _____
☐	☐	Hemorrhoids _____
☐	☐	Liver Disease (Cirrhosis, Hepatitis, etc.) _____
☐	☐	Kidney Disease (Cysts, Stones, Infection, etc.) _____
☐	☐	Bladder Infections _____
☐	☐	Prostate Disorders (Males only) _____
☐	☐	Female Organ Disorders _____
☐	☐	Stroke _____
☐	☐	Paralysis _____
☐	☐	Cancer _____
☐	☐	Epilepsy _____
☐	☐	Serious Injuries _____
☐	☐	Meningitis _____
☐	☐	Encephalitis _____
☐	☐	Polio _____
☐	☐	Sickle Cell Disease _____

643-0010 (10-92)dlh(MPC#351)

Radiation treatments to head or neck _____
Emotional problems _____
Phlebitis _____
Glaucoma _____
Cataract _____
Gout _____
Other (Please list) _____

Last Hospitalization (date and diagnosis) _____

_____

Previous Procedures (approximate date):

Chest X-ray _____ EKG _____

Flu Vaccine _____ Pneumococcal Vaccine _____

Tetanus Shot _____ Tuberculosis Skin Test _____

Stomach X-ray (UGI) _____ Colon X-ray (BE) _____

Kidney X-ray (IVP) _____ Complete Medical Examination _____

Sigmoidoscopic / Proctoscopic Exam _____ Pelvic Exam and Pap Smear (females only) _____

PAST SURGICAL HISTORY (List operations, dates and where performed):

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

CURRENT MEDICATIONS (Name and dosage):

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

OVER-THE-COUNTER MEDICATIONS/HERBALS/VITAMINS:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

ALLERGIES (to drugs). Please give reaction (i.e. shock, hives, chest pain, etc.):

1. _____ 3. _____
2. _____ 4. _____

SOCIAL HISTORY:

Do you smoke cigarettes? ▫Yes ▫No If no, have you ever smoked? ▫Yes ▫No

How many packs per day? _____ For how many years have you smoked? _____
When did you quit? _____

Do you drink alcohol? ▫Yes ▫No How much? _____

How much coffee/tea/caffeinated drinks do you drink? _____

FAMILY HISTORY: (Please list age and any medical problems:

Father, age _____ Mother, age_____

How many brothers? _____ How many sisters? _____

Any with medical problems? _____

DO ANY OF THE DISEASES RUN IN YOUR FAMILY?

YES	NO		YES	NO	
☐	☐	Cancer	☐	☐	Tuberculosis
☐	☐	Heart disease	☐	☐	Strokes
☐	☐	High blood pressure	☐	☐	Diabetes
☐	☐	Sickle cell anemia	☐	☐	Epilepsy
☐	☐	Thyroid disease	☐	☐	Suicide
☐	☐	Kidney disease - stones	☐	☐	Colitis

Richard C. W. Hall, MD, PA
2500 W. Lake Mary Blvd; Ste. 219
Lake Mary, FL 32746

PATIENT QUESTIONNAIRE (for Forensic Examination)

ALL QUESTIONS MUST BE ANSWERED

WARNING: Because you are being examined for purposes of legal action (workers' compensation, social security, civil rights, civil or criminal, etc.), please be aware that the information you supply in this questionnaire, or tell the doctor, is not confidential.

GENERAL INFORMATION

Name: _____ Today's date: _____

Address: _____ City: _____

State, ZIP: _____ Date of Birth: _____ Age: _____

Phone: _____ Social Security Number: _____

Which is your dominant hand? (right, left, both): _____

Can you read a newspaper? Yes_____ No_____ Your present weight: _____

Current employment: _____

Education (highest grade completed): _____

Physician, lawyer or person who referred you to this office: _____

_____

If you are being examined for Workers' Compensation, Social Security, a lawsuit, or criminal charges, who is your lawyer? _____

Did you drive yourself here today? Yes____ No____ If no, who brought you? _____

What is the driver's relationship to you (friend, relative, hired by your lawyer, etc.) _____

_____ Who do you live with at this time? _____

HISTORY OF PRESENTING PROBLEM

Have you been experiencing any mental or nervous problems in the last month? Yes____ No____

If yes, describe: _____

When did your mental problem first begin? _____

_____

Have you been experiencing any physical problems in the last month? Yes____ No____ If yes, describe: _____

_____

When did your physical problems first begin? _____

ACTIVITIES OF DAILY LIVING

What time do you get up in the morning? _____ What time do you go to bed at night? _____ Who fixes your breakfast? _____ Do you drive a car or truck?_____ Do you use a checkbook?_____ Who pays your bills? _____ Who cleans your home? _____ Who fixes your meals? _____ Do you attend church? _____ How often? _____

What hobbies do you now have? _____

What do you read? _____

What TV shows are presently your favorite(s)? _____

What do you do with your children? _____

What was your last overnight trip? _____

Who mows your yard? _____ What work do you do around your home or farm? _____

How many movies do you rent per month? _____ How many times do you go to the movie theater a year? _____ How many times do you sleep away from home in a year? _____ How many ball games do you attend in a year? _____ How many times do you hunt in a year? _____ How many times do you fish per year? _____ How many times do you eat out in a month? _____ How many times a month do friends or family visit in your home? _____ How many times a week do you call someone on your phone? _____ What plants do you grow? _____ Can you dress yourself? _____ Can you bathe yourself or shower yourself? _____ Can you have sex? _____

PAST MEDICAL HISTORY

List any serious childhood illnesses you had: _____

Were you born prematurely? Yes____ No____ What did you weigh at birth?_____

Did you have growth problems? Yes____ No____ Were you sad or happy or depressed as a child? Sad____ Happy____ Depressed____ List any permanent physical or mental problems from childhood: _____

As a child, did you have trouble sitting still in school? Yes____ No____ Did you have trouble learning in school? Yes____ No____ Did you have trouble keeping your mind on things as a child? Yes____ No____ Did you have trouble learning to read? Yes____ No____ Did teachers complain that you were too active? Yes____ No____

Check any serious illnesses you have now or have been treated for in the past:

____ Seizures
____ Cancer
____ Diabetes
____ Thyroid Disease
____ Anemia (low blood)
____ High blood pressure
____ Heart disease
____ Lung or breathing problems
____ Joint or back disease
____ Stomach or bowel disease
____ Female problems
____ Pregnancy problems
____ Urinary tract problems
____ Sexual problems
____ Prostate problems
____ Sleep problems

____ Depression
____ Panic disorder
____ Nerves
____ Alcoholism
____ Drug abuse
____ Overdoses
____ Suicide attempts
____ Violence towards others
____ Attention deficit disorder
____ Manic depressive
____ Schizophrenia
____ Eating disorders
____ Neurological disease
____ Spouse abuse
____ Child abuse or neglect

If you were hospitalized for these illnesses, list the hospital(s): _____

_____

Have you had any motor vehicle accidents? Yes____ No____ If yes, list them:

Date	Your age at the time	Type of injury	Treatment/by whom

Have you ever been knocked out, lost consciousness or had a brain injury? Yes____ No____

If yes, describe what happened: _____

_____

Have you ever broken any bones? Yes____ No____ If yes, describe which bones were broken, right or left side: _____

For women: How many pregnancies have you had? _____ How many living children have you had? _____ How many miscarriages have you had? _____

Could you be pregnant? Yes____ No____ When was your last menstrual period? _____

Have you had any surgeries or operations? Yes____ No____ If yes, list below:

Date	Your age at the time	Hospital where performed	Type of surgery

Are you now taking any medications? Yes____ No____ Please list the milligrams and how often you take your medicine.

Medication	Milligrams	Times per day

Who keeps track of your medications? You ____ Your spouse ____ Someone else _____

Do you have any drug allergies or reactions? Yes____ No____ If yes, list below:

Drugs	Allergic Reaction
	(Rash, nausea, hives, etc.)

Do you use tobacco now? Yes____ No____ Not now but previously ____ If yes or have used tobacco in the past, please describe how much and how long used: _____

_____

Do you use alcohol now? Yes____ No____ Not now but in the past ____ If yes to any use of alcohol, describe:

Type of alcohol (whiskey, beer, wine, etc.): _____

Number of alcoholic drinks you have per day: _____

How long alcohol was used before you stopped: _____

Describe any medical treatment for alcohol problems: _____

Describe any present alcohol problems in your life: _____

Have you ever taken a medication or drug that you received from friends or family or bought off the street? Yes____ No____ If yes, describe: _____

Have you ever used illegal drugs, (*i.e.* marijuana, cocaine, uppers, downers, crack, etc.)? Yes____ No____

Have you ever sniffed paint, solvents or gasoline to get high? Yes____ No____ If yes, what did you sniff and how long? _____

Have you ever used illegal intravenous drugs (IV drugs)? Yes____ No____

Have you ever received treatment for drug/substance abuse? Yes____ No____ If yes, what hospital, what year? _____

Using the chart below, list what type of illegal drugs you have used:

Drug/Substance	Age at use	How long used	Last date used

Do you drink coffee or tea? Yes____ No____ How many cups per day? _____ Do you drink caffeinated soft drinks? Yes____ No____ What soft drinks? _____ How many per day? _____

Psychiatric hospital admission	Year hospitalized	Hospital name	Treating physician or psychiatrist	Diagnosis or reason for admission	Type of treatment received
1st admission					
2nd admission					
3rd admission					
4th admission					

Have you ever been discharged from any hospital Against Medical Advise (AMA)? Yes____ No____ If yes, describe? _____

Have you ever stopped taking nerve pills without asking the doctor? Yes____ No____

Have you ever been prescribed any form of nerve medicines, antidepressants, or other psychiatric medications? Yes____ No____ If yes, describe: _____

When is the first time you ever took nerve medicines or antidepressants? _____

_____

Have you ever had shock treatments (ECT)? Yes____ No____ If yes describe when and where:

_____

_____

Have you ever been advised by any doctor or health practitioner to get mental or psychological treatment? Yes____ No____ If yes, describe: _____

_____

Have you ever been committed to a mental hospital or psychiatric unit? Yes____ No____ If yes, describe: _____

_____

Have you ever refused mental treatment: Yes____ No____ If yes, describe: _____

_____

Have you ever received any type of office treatment by your family doctor, psychiatrist, psychologist or therapist (medication, counseling, therapy) for any nervous condition, psychological, psychiatric, family or marital problems? Yes____ No____ If yes, describe:

Date	Your age at the time	Type of injury	Treatment/by whom

Have you ever intentionally overdosed yourself on drugs or medicines? Yes____ No____

If yes, describe: _____

Have you ever attempted to take your life? Yes____ No____

If yes, describe: _____

Have you ever cut, burned or disfigured yourself? Yes____ No____

If yes, describe: _____

FAMILY HISTORY

Please check if any of these illnesses have occurred in any of your parents, grandparents, brothers, sisters or children:

____ diabetes
____ cancer
____ heart disease
____ lung disease
____ mental illness/nerve problems
____ violence towards others
____ spouse abuse
____ high blood pressure
____ thyroid illnesses
____ alcohol/drug problem
____ eating disorders
____ suicide
____ killing another person
____ child abuse

If you checked any of the above, please explain which relative had the illness: _____

_____

_____

Father's age if living: _____ Mother's age if living: _____ If father, mother, brothers, sisters or child has died, list the cause of death and age at death: _____

_____

_____

SOCIAL HISTORY

Where were you born? _____

Date of birth: _____ How many children were in your family? _____

Of your siblings, how many sisters? _____ How many brothers? _____ Where do you come in the family (first child, last child, etc.) _____

What did your father do for a living? _____

What did your mother do for a living? _____

Did your family have enough money? _____ Not enough money? _____ Live in poverty? _____

Is your father living? _____ Year he died: _____ Your mother? _____ Year she died: _____

Are (were) your parents divorced? _____ If yes, when? _____ How old were you at the time? _____ Who raised you? _____ Did your parent(s) own your home? Yes____ No____ Was your home happy? Yes____ No____ Abusive? Yes____ No____ Threatening? Yes____ No____ Hard on you? Yes____ No____ Make you feel depressed? Yes____ No____ _____

Did your father abuse your mother? Yes____ No____ _____

Have you ever been sexually abused? Yes____ No____ _____

Have you ever been physically abused? Yes____ No____ _____

Have you ever been violent to or harmed a person, animal or property? Yes____ No____

Have you ever shot, stabbed, or beaten another person? Yes____ No____

Have you ever threatened to kill another person? Yes____ No____

Have you ever killed another person, even if by accident? Yes____ No____

Describe your abuse or violence of others, if it occurred. _____

Have you ever been in trouble for your sexual behavior? Yes____ No____

Have you ever sexually abused or harassed a child or adult? Yes____ No____

Highest grade you completed in school? _____

If you did not finish high school, what was the reason you quit? _____

What were your grades in high school? _____ Were you in special education classes? Yes____ No____ In school, did the teachers think you were hard to control or was it hard to get your attention? Yes____ No____

If you attended any college, list college/university, degree, and date of graduation:

College/University	Degree	Date of graduation

Are you never married, married, or divorced? _____

How long have you been divorced or married? _____

Marriage	Year married	Year divorced	Spouse's name	Any natural children and their ages	Reason for divorce
First marriage					
Second marriage					
Third marriage					
Fourth marriage					

How many natural children do you have? _____ How many step-children? _____

How would you describe your marriage if you are married? Good relationship ____ Fair relationship ____ Bad relationship ____ Terrible or abusive relationship ____

If you are not married and have a lover, describe your relationship: Good ____ Fair ____ Bad ____ Terrible or abusive ____

Describe your relationship with your children. Close____ Could be better____ Distant____ Poor____

If you do not have a relationship, how do you feel about this? Satisfied____ Lonely but OK____ Not satisfied and want a relationship____ Very sad and lonely____

LEGAL HISTORY

Have you had any criminal convictions, drug arrests, DUIs or public intoxication arrests? Yes____ No____ If yes, fill in below:

Arrest date	Charge(s)	Where (City or State)	Were you convicted?	Length of time in prison/jail

Have you been involved in any civil law suits as either the plaintiff or defendant? Yes____ No____

If yes, describe: _____

If you received a monetary award, how much was it? _____

Has your spouse, or any one else, ever gotten a restraining order or emergency protective order against you? Yes____ No____ If yes, describe:_____

Have you ever gotten a restraining order or emergency protective order against your spouse, or anyone else? Yes____ No____ If yes, describe:_____

Have you ever filed a Workers' Compensation claim: Yes____ No____ If yes, how many?_____

Describe each injury and the year it occurred: _____

_____

Give the amount of your award or the monthly benefit:_____

Have you ever been charged with spouse abuse, child abuse or neglect, or terroristic threatening? Yes____ No____ If yes, describe:_____

EMPLOYMENT/VOCATIONAL HISTORY

Employment status: (check one) Full time____ Part time____ Not employed____ Student____

If not employed, reason you are not employed:_____

_____

_____

_____

If employed, who is your present employer?_____

Employer's address:_____

_____

Length of time on your last permanent job:_____

Job Title/Position of that job:_____

If you are disabled, year of and reason for your disability: Year_____ Reason_____

_____

What are your present sources of all monthly income? _____

_____

Were you ever fired or asked to resign from a job? Yes____ No____ If yes, reason:_____

_____

Have you ever threatened your employer or a coworker? Yes____ No____

Where is your spouse employed?_____

_____

Do you plan to return to work at any time in the future? Yes____ No____

List past employment (beginning with your most recent job):

Employer	Job Title	Start date	Finish date	Reason for leaving	Other

(Continue on page 11.)

Employment history (cont.)

Employer	Job Title	Start date	Finish date	Reason for leaving	Other

MILITARY HISTORY

Have you had any military service? Yes___ No___ If yes, list below:

Branch of Service	Years served	Rank at time of discharge	Type of discharge	Job duties

Where was your basic training? _____

Where was your advanced training? _____

If you ever served in a combat zone, list dates and area: _____

_____

If wounded in military service, describe: _____

_____

List any promotions/advancements and dates: _____

_____

List any medals/commendations and dates awarded: _____

_____

Were there any disciplinary actions against you? Yes___ No___ If yes, describe:_____

_____

Were you ever in the brig or stockade? Yes____ No____

Describe any military pension or disability: _____

REVIEW OF SYSTEMS

(Circle those symptoms present)

GENERAL Fever, shaking, chills, change in appetite, loss in weight, change in weight, fatigue, change in sleeping patterns, soaking night sweats.

Explain any circled items. If you have lost or gained weight, how many pounds in the last 3 months?

_____

_____

_____

HEAD, EYES, EARS, NOSE, THROAT Headache, changes in vision, double vision, blurred vision, eye pain, excessive tearing, discharge from the eyes, changes in hearing, ringing in ears, ear pain, discharge from ears, nosebleeds, odd odors, hoarseness, dental pain, sore tongue, sore throat, mouth sores.

Explain any circled items: _____

_____

_____

_____

CHEST Cough, sputum production, shortness of breath, wheezing, blood in sputum, abnormal chest x-ray, positive TB test, lump(s) in breast, nipple discharge, nipple bleeding, breast pain.

Explain any circled items: _____

_____

_____

_____

HEART Chest pain, shortness of breath walking, shortness of breath upon lying down, heart murmur, rheumatic fever, shortness of breath that wakes you up at night, swelling in legs, fainting.

Explain any circled items: _____

_____

STOMACH, BOWEL Change in appetite, nausea, vomiting, blood in vomit, dark brown vomit, diarrhea, constipation, change in stool size, blood in stool, dark black tarry-colored stool, food intolerance, trouble swallowing, heartburn, indigestion, laxative use, excessive gas, abdomen pain, weight loss, weight gain.

Explain any circled items: _____

URINARY, GENITAL Trouble starting urination, excessive urination, dribbling of urine, pain upon urination, blood in urine, excessive urination after going to bed, unable to hold urine, bed wetting, sores on genitals.

Explain any circled items: _____

FEMALE Menstrual irregularity, premenstrual distress, menopause symptoms, excessive female bleeding.

Explain any circled items: _____

MENTAL Depression, nervousness, panic, thoughts of suicide, poor concentration, loss of memory, too happy, word-finding difficulty, confusion, inability to know month/year, hearing voices, seeing things, paranoid thoughts, irritability, arguing, crying for no reason, trouble thinking, flashbacks, thoughts of killing another person, counting things, checking things, afraid of germs, afraid to touch doorknobs, wash hands more than 10 times daily, take more than 2 baths or showers daily. Do you have a present plan to kill yourself? Yes____ No____ Do you have a plan to kill someone else? Yes____ No____

Explain any circled items: _____

NEUROLOGIC Blackouts, seizures, double vision, partial blindness, headaches, numbness, tingling, weakness, poor balance, shaking or tremors, abnormal movements of face or body, poor coordination, paralysis, loss of reflexes, pain.

Explain any circled items: _____

MUSCLES, SKELETAL

Muscle spasms, joint pain, bone disorders, difficulty walking, difficulty sitting, difficulty using hands, difficulty bending, difficulty lifting.

Explain any circled items: _____

SLEEP

Cannot fall asleep, cannot stay asleep, wake up too early, fall asleep any time, night terrors, nightmares, sleep walking, restless legs before sleep, cannot stay awake during or while sitting, severe snoring that bothers others, choking during sleep, cannot stay awake to drive, others have observed you to stop breathing during sleep.

Explain any circled items: _____

SEXUAL

Men: Cannot get erection, cannot ejaculate, ejaculate too soon, no sexual desire, partner does not meet your needs.

Women: Cannot lubricate, cannot have orgasm, no sexual desire, partner does not meet your needs.

How many times per month do you engage in sexual activity with another person or a spouse? _____

Explain any circled items: _____

HIV

Could you be HIV positive? Yes____ No____

AUTHORIZATION INFORMATION

I authorize Richard C. W. Hall, M.D., to examine and test me. (If you are under 18 years of age, your parent or guardian must sign this form.)

_____
Signature

_____
Date

I authorize this office to send a copy of this evaluation to the person or agency who requested me to be examined or to those parties involved in my care.

_____
Signature

_____
Date

By my signature, I certify all statements I answered on this Questionnaire are true and accurate.

_____
Signature

_____
Date

If this form was filled out by someone other than the patient, please give name and relationship to patient (spouse, friend, parent, guardian, etc.)

Name: _____ Relationship: _____