# Questionnaire for Prospective Patients

Please read the following before answering the questions in this questionnaire:

The information which you provide will be held in the strictest confidence. Videotaping is done as part of therapy for in-house use only. Should The Primal Center decide to publish any of the information or statistical data gathered from the questionnaire, you will not be personally identified. Please read each question carefully before you respond. You may print out this questionnaire and mail it to us, or complete it here, online (when you are done, click on the "E-mail Questionnaire" button at the bottom).

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| Name: |  |
| Applying as: | Select Patient Trainee |
| How did you find out about: |
| Primal Therapy?: | SelectThe Primal ScreamThe New Primal ScreamWhy You Sick, How You Get Well The Biology Of LoveOther (Please Specify) |
|  | If other, please specify: |
| The Primal Center?: | Select Books ReferralWord of Mouth PatientsOther (Please Specify) |
|  | If other, please specify: |

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| Have you read any of Dr. Arthur Janov's books?: | Select YesNo |
|  | If yes, which one(s)?: |
| Contact Information: |
| Email: |  |
| Tel.: |  |
| Fax: |  |
| Address: |  |
| City: |  |
| State/Prov: |  |
| Country: |  |
| Zip Code: |  |
| Nationality: |  |
| Personal Information |
| Languages Spoken: |  |
| Age: |  |
| Birth Date: |  |
| Sex: | Select MaleFemale |
| Education: | Select9-12 Years in school University graduateGraduate of professional school |
| Profession: |  |
| Spouse's profession: |  |
| Weight: |  |
| Height: |  |

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| Current marital status: | Select Single MarriedDivorced |
| Number of children and ages: |  |
| Religion: |  |
| Country and area where you spent themajority of your childhood: |  |
| Number of children in family: |  |
| Which number child were you in your family?: |  |
| You were raised for the majority of your childhood by: | SelectSingle mother Single father Other (explain) |
|  | If other, please specify: |
| During your childhood were you sent away from your natural home?: | Select YesNo |
| If yes, indicate where: | To live with relatives To boarding schoo To a foster homeTo an institution |
| Family's economic status during childhood: |  |
| Birth Information |  |
| What kind of birth did you have?: |  |

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|  | SelectNormal Delivery Forceps delivery Caesarean section Breach deliveryMultiplepregnancy (i.e. were you a twin, triplet, etc) |
| Indicate (if known) the circumstances at the time of your birth delivery (number of weeks): | Select Full TermPrematurePost Term |
| Duration of labor in hours: |  |
| Were you below normal weight for your gestation age at the time of delivery: | Select YesNo |
| Did your mother receive pain relieving drugs or anesthesia during labor??If yes, indicate which: |  |
| Did you require active resuscitation after birth (as needed with babies born blue)?: | Select YesNo |
| Did you spend time in an incubator or a special baby unit after birth?: | Select YesNo |

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| Were you circumcised shortly after birth?: | SelectYes No |
| Were you breast fed?: | SelectYes No |
| Medical Information |  |
| Do you have suicidal impulses?: | Select YesNo |
|  | If yes:Frequently Rarely |
| Have you ever attempted suicide?: | SelectYes No |
| If yes, indicate method: |  |
| Have you ever been admitted to a hospital for psychiatric treatment?: | SelectYes No |
| If yes, how many times?: |  |
| Total duration of stay: |  |

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| Have you ever been raped?: | SelectYes No |
|  | If yes, was it incestuous?:Yes No |
| Were you ever molested?: | SelectYes No |
| If yes, by whom?: |  |
| For how long?: |  |
| Do you use recreational drugs, or have you used them in the past? | SelectYes No |
| If yes, which and for how long? |  |
| If LSD, how many trips? When? |  |
| If cannabis/hashish, for how long? |  |
| Are you currently on tranquilizers? | Select YesNo |
| Which? Dosage? |  |
| Are you taking any (other) prescriptionmedication? Which? How often? |  |
| Are you subject to heavy use of alcohol? | Select |

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|  | YesNo |
| Have you ever been diagnosed as being alcoholic? | SelectYes No |
|  | If yes, have you had treatment for this?:Yes No |
| Do you regularly smoke tobacco? | Select YesNo |
| If yes, how many cigarettes per day? |  |
| On average how many cups of tea/coffeedo you drink per day? |  |
| Do you regularly suffer from any of the following features of anxiety (see list in box just below"If yes, indicate appropriately")? | Select YesNo |
| If yes, indicate appropriately: | Panic attacks Apprehension or fear Shaking or trembling Inability to relaxEasily fatigued |

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|  | Anticipation or misfortune to self or others Startle reactionsImpatienceOther |
|  | If other, please specify: |
| Are you subject to depression? | Select YesNo |
|  | If yes, is it:Severe Frequent MildRare |
| Do you suffer from phobias? | SelectYes No |
| If yes, indicate which: |  |
| Are you subject to recurrent thoughtsthat enter your mind in an obsessive fashion? | SelectYes No |
| Do you have frequent muscle tension? |  |

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|  | SelectYes |
| Do you have high blood pressure? | SelectYes No |
|  | If yes, are you on medication for this?:Yes No |
| What type?: |  |
| Are you subject to palpitation? (Where you feel your heart beating rapidly): | Select Yes No |
| Are you subject to excessively cold hands and/or feet? | Select YesNo |
| Have you been diagnosed to have any other disease of the heart or circulation? | Select Yes No |
|  | If yes, indicate diagnosis: |
| Do you have asthma? | Select |

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|  | YesNo |
|  | If yes, have you been hospitalized?:Yes No |
| Do you have tension headache? | Select YesNo |
|  | If yes, is it:Severe Mild FrequentRare |
| Do you suffer with migraine which has been medically diagnosed? | SelectYes No |
|  | If yes, are attacks:Frequent Rare |

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| Are your menstrual periods usually regular? | SelectYes No |
| Do you suffer from P.M.S.? | SelectYes No |
| On average how many hours sleepdo you have per night? |  |
| Do you feel rested when you get up in the morning? | Select OccasionallyRarely |
| Do you usually have difficulty in falling asleep? | Select Frequently RarelyNo |
| Do you use hypnotic drugs (Sleeping pills) to ensure sleep? | Select Every NightOccasionallyNo |
| If yes, indicate which: |  |
| Do you have nightmares? | Select Frequently |

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|  | RarelyNo |
| If yes, indicate general theme: |  |
| Are you active in? | SelectHomosexual fantasies Voyeurism TransvestismFrequent desire for pornographic literature ExhibitionismFantasies or impulses to rap Fantasies of being raped SadomasochismOther |
| Additional information, if necessary: |  |
| Is your sexual preference predominantly? | Select Heterosexual HomosexualBi-Sexual |
| Have you had any of the following psychological treatments? Please check any that you have had: |
| Psychoanalysis: |  |
| Transactional analysis: |  |
| Behavior modification: |  |
| Bioenergetics: |  |
| Transcendental meditation: |  |
| Hypnotherapy: |  |
| Biofeedback: |  |
| Rebirthing: |  |
| Electro-shock: |  |

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| Drug therapy: |  |
| Co-counseling: |  |
| Other Information |
| Do you ever cry?: | SelectYes No |
| When was the last time you cried? |  |
| Have you had previous Primal Therapy? | Select Yes |
| If yes, Where? |  |
| With Whom? |  |
| When? |  |
| For how long? |  |
| Why did you stop? |  |
| Social life: How would you rate it? | Select Good Mediocre BadEpisodic |
| Work history? Brief list of the last5 years' work: Occupation & Duration: |  |
| Do you have an intimately close relationship with one or more people in your life? | Yes No |
| If yes, how many close friends? For how long?: : |  |
| Do you have a close relationship with one or both of your parents or your siblings? | SelectYes No |

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| If yes: | Father MotherBoth Father & Mother Brother(s)Sister(s) |
| Have you ever been subjected to violence? | Select YesNo |
| If yes, please explain: |  |
| Have you ever engaged in any violent behavior? | SelectYes No |
| If yes, please explain: |  |
| What do you expect from the therapy? |  |
| Why do you want to be a patient (or trainee)?: |  |
| How do you plan to financethe therapy and follow up? |  |
| When would you like to startPrimal Therapy (month and year)? |  |
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