# 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?: | Select  The Primal Scream  The New Primal Scream  Why You Sick, How You Get Well The Biology Of Love  Other (Please Specify) |
|  | If other, please specify: |
| The Primal Center?: | Select Books Referral  Word of Mouth Patients  Other (Please Specify) |
|  | If other, please specify: |

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| Have you read any of Dr. Arthur Janov's books?: | Select Yes  No |
|  | 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 Male  Female |
| Education: | Select  9-12 Years in school University graduate  Graduate of professional school |
| Profession: |  |
| Spouse's profession: |  |
| Weight: |  |
| Height: |  |

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| Current marital status: | Select Single Married  Divorced |
| Number of children and ages: |  |
| Religion: |  |
| Country and area where you spent the  majority 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: | Select  Single mother Single father Other (explain) |
|  | If other, please specify: |
| During your childhood were you sent away from your natural home?: | Select Yes  No |
| If yes, indicate where: | To live with relatives To boarding schoo To a foster home  To an institution |
| Family's economic status during childhood: |  |
| Birth Information |  |
| What kind of birth did you have?: |  |

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|  | Select  Normal Delivery Forceps delivery Caesarean section Breach delivery  Multiplepregnancy (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 Term  Premature  Post Term |
| Duration of labor in hours: |  |
| Were you below normal weight for your gestation age at the time of delivery: | Select Yes  No |
| 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 Yes  No |
| Did you spend time in an incubator or a special baby unit after birth?: | Select Yes  No |

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

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| Have you ever been raped?: | Select  Yes No |
|  | If yes, was it incestuous?:  Yes No |
| Were you ever molested?: | Select  Yes No |
| If yes, by whom?: |  |
| For how long?: |  |
| Do you use recreational drugs, or have you used them in the past? | Select  Yes 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 Yes  No |
| Which? Dosage? |  |
| Are you taking any (other) prescription  medication? Which? How often? |  |
| Are you subject to heavy use of alcohol? | Select |

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|  | Yes  No |
| Have you ever been diagnosed as being alcoholic? | Select  Yes No |
|  | If yes, have you had treatment for this?:  Yes No |
| Do you regularly smoke tobacco? | Select Yes  No |
| If yes, how many cigarettes per day? |  |
| On average how many cups of tea/coffee  do 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 Yes  No |
| If yes, indicate appropriately: | Panic attacks Apprehension or fear Shaking or trembling Inability to relax  Easily fatigued |

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|  | Anticipation or misfortune to self or others Startle reactions  Impatience  Other |
|  | If other, please specify: |
| Are you subject to depression? | Select Yes  No |
|  | If yes, is it:  Severe Frequent Mild  Rare |
| Do you suffer from phobias? | Select  Yes No |
| If yes, indicate which: |  |
| Are you subject to recurrent thoughts  that enter your mind in an obsessive fashion? | Select  Yes No |
| Do you have frequent muscle tension? |  |

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

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

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|  | Rarely  No |
| If yes, indicate general theme: |  |
| Are you active in? | Select  Homosexual fantasies Voyeurism Transvestism  Frequent desire for pornographic literature Exhibitionism  Fantasies or impulses to rap Fantasies of being raped Sadomasochism  Other |
| Additional information, if necessary: |  |
| Is your sexual preference predominantly? | Select Heterosexual Homosexual  Bi-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?: | Select  Yes 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 Bad  Episodic |
| Work history? Brief list of the last  5 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? | Select  Yes No |

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| If yes: | Father Mother  Both Father & Mother Brother(s)  Sister(s) |
| Have you ever been subjected to violence? | Select Yes  No |
| If yes, please explain: |  |
| Have you ever engaged in any violent behavior? | Select  Yes 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 finance  the therapy and follow up? |  |
| When would you like to start  Primal Therapy (month and year)? |  |
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# SUBMIT