

Stonebriar Psychiatric Services, P.A.
Medical History

Name: _____ Age: ____ M ____ F ____ Date: _____ DOB _____

Address: _____ City: _____ Zip: _____

SS # _____ Home Phone: _____ Work phone: _____

Cell phone: _____ E-mail Address: _____

Emergency contact Name/Relationship/Number _____

How did you hear about our office: _____

Primary Care Physician/Address: _____

Date of Last Physical: _____

HISTORY OF PAST ILLNESS: Have you had

Childhood

- Measles Rheumatic fever or heart disease
 Congenital Abnormalities Mumps Chicken Pox

Adult:

- Asthma High Blood Pressure Cancer
(Site _____)
 Diabetes Ulcer or Gastritis Thyroid Problems
 Tuberculosis Kidney Problem Liver Problem
 Blood Problem Venereal Disease Heart Failure
 Heart Attack Abnormal Heart Rhythm
 Osteopenia/osteoporosis

OPERATIONS:

Have you ever had any surgery? yes no

If yes, what type and when:

ALLERGIES:

CURRENT MEDICATIONS:

INJURIES:

Have you ever been in a serious motor vehicle accident? yes no

Have you had any head concussions or injuries? yes no

Have you ever been knocked unconscious? yes no

PAST PSYCHIATRIC HISTORY:

List all therapists, counselors and hospitalizations (with dates)

List **all** past psychiatric medications:

SOCIAL HISTORY:

Circle One: Single Married Separated
Divorced Widowed Significant Other

With whom do you live? _____

History of Drug Usage? yes no

Do you have concerns regarding sexual function? yes no

Foreign Travel within the past year _____

Coffee _____ Tea _____ Colas _____ per day

Alcohol Never < 1 per week 1-5 per week Other

Tobacco: Never smoked Quit _____ years ago

Packs per day Years smoked _____

SOCIAL HISTORY: (continued)

Are you employed? Full Time Part Time

What is your job? _____

Are you a student? yes no If so, where _____

How much time have you lost from work or school because of your health during the past: Six months _____ One year _____

5 Years _____

Education: (Years)

Grade School _____ College _____ Postgraduate _____

Do you wear seatbelts? Always Sometimes Never

FAMILY HISTORY	AGE	HEALTH	If Deceased, Age @ Death	Cause of Death
Father				
Mother				
Brother/Sister				
Husband/Wife				
Son/Daughter				

Has either parent, sister, brother, child or grandparent ever had psychiatric problems, substance abuse, or treatment? If so, what type of illness and treatment _____

Has any blood relative had diabetes Yes No

Has any blood relative ever attempted or completed suicide? Yes No

SYSTEMIC REVIEW:

WEIGHT: Current _____ Max. _____ Min. _____

Recent weight change? Yes No

Height _____ Neck Circumference: _____ inches

Have you recently had: Weakness Fever Chills
 Fainting Problems Sleeping Night Sweats

CIRCLE if you have had the following:

SKIN

Skin Disease Yes No
Jaundice Yes No
Hives, eczema, rash Yes No

Head-Eyes-Ears-Nose-Throat

Dry eyes or mouth Yes No
Bleeding gums – frequent or consistent Yes No
Blurred vision Yes No
Date of last eye exam _____
Nosebleeds – frequent Yes No
Chronic sinus trouble Yes No
Ear disease Yes No
Impaired hearing Yes No
Dizziness or sensation of room spinning Yes No
Frequent or severe headaches Yes No

Respiratory

Asthma or Wheezing Yes No
Difficulty breathing Yes No
Pleurisy or Pneumonia Yes No
Cough up Blood (ever) Yes No

Cardiovascular

Chest pain, pressure or tightness Yes No
Shortness of breath with walking or lying down Yes No
Palpitations Yes No
Swelling of hands, feet or ankles Yes No
Awakening in the nights feeling smothered Yes No
Heart murmur Yes No

Gastrointestinal

Vomiting blood or food Yes No
Gallbladder disease Yes No
Change in appetite Yes No
Hepatitis / Jaundice Yes No
Painful bowel movements Yes No
Bleeding with bowel movements Yes No
Black stools Yes No
Recent change in bowel habits Yes No
Frequent diarrhea Yes No
Heartburn or indigestion Yes No
Cramping or pain in the abdomen Yes No
Does food stick in throat Yes No

Endocrine

Hormone therapy Yes No
Any change in hat or glove size Yes No
Any change in hair growth Yes No
Have you become colder than before or skin dryer Yes No

Neck

Stiffness Yes No
Enlarged glands Yes No

Genitourinary:

Loss of urine Yes No
Blood in urine Yes No
Frequent urination Yes No
Burning or painful urination Yes No
Bedwetting Yes No
Kidney trouble Yes No
Testicular mass Yes No
Prostate problem Yes No
Sexual dysfunction Yes No
STD / AIDS risk Yes No

Gynecological:

First day of last period _____
Age periods started _____
How long do periods last _____
Frequency of periods every _____
Pain with periods Yes No
Number of pregnancies _____
Number of miscarriages _____
Date of last cancer smear and results _____
Breast lump or discharge Yes No
Abnormal vaginal discharge Yes No
Pain with intercourse Yes No

Locomotor-musculoskeletal

Stiffness or pain in joints Yes No
Weakness of muscles or joints Yes No
Any difficulty walking Yes No
Any pain in calves/buttocks with walking relieved w/rest ... Yes No

Neuro-Psychiatric

Transient blindness Tremor Weakness Fingers numb
Have you ever had counseling for mental health Yes No
Have you ever been advised to see a psychiatrist Yes No
Have you or do you ever have fainting spells Yes No
Convulsions Yes No
Paralysis Yes No
Problems with coordination Yes No
History of being physically or sexually abused Yes No
Depression symptoms (difficulty sleeping, loss of appetite, loss of interest in activities, feeling hopeless) Yes No
History of ADHD Yes No
History of mood swings or bipolar illness Yes No
History of bingeing or purging Yes No

Hematologic

Are you slow to heal after cuts Yes No
Anemia Yes No
Phlebitis or blood clots in veins Yes No
Have you had difficulty with bleeding excessively after tooth extraction or surgery? Yes No
Have you had abnormal bruising or bleeding Yes No

Other

Do you snore loud enough to be heard through a closed door? Yes No
Do you often feel tired, fatigued during the day? Yes No
Has anyone observed you stop breathing during sleep? Yes No
Do you have/are you being treated for high blood pressure? Yes No

The information provided herein is accurate to the best of my knowledge. I understand it is my responsibility to inform my doctor of any changes in this information.

Patient signature: _____ Date: _____ Provider: _____

Signature of person providing this information: _____

Stonebriar Psychiatric Services, P.A.

Name: _____ Date: _____

Date of Birth: _____ Social Security #: _____

Home Address: _____ City, State, Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

May we leave messages at home? Yes No

May we leave messages at work? Yes No

May we send mail to you at this address? Yes No

Marital Status: S M D W Date of Current Marriage/Separation: _____

Number of Marriages: _____

Spouse's Name: _____ Date of Birth: _____

Child(ren)'s Name(s): _____ Date of Birth: _____ M F

_____ Date of Birth: _____ M F

_____ Date of Birth: _____ M F

Previously Married? Yes No If yes, when? _____ How long? _____

Occupation: _____ Highest Level of Education: _____

COUNSELING AND PSYCHIATRIC HISTORY

Have you had previous counseling? Yes No If yes, when? _____

Name and location of counselor: _____

If yes, for what reason? _____

For how long? _____ Was it helpful? _____

Have you ever been diagnosed with or treated for any type of mental illness? Yes No If yes, which type? _____

Has anyone in your family ever been diagnosed with or treated for any type of mental illness? Yes No

If yes, who and which type? _____

REASONS FOR SEEKING HELP

What concerns have brought you to counseling today? _____

Which of the following are causing the most concern for you? Please check all that apply:

- Home Work Marriage Other Relationships God

When did your present concerns begin to be a problem for you? _____

What concerns about you have been identified by others? _____

Please rate the severity of your present concerns on the following scale. Check one:

- Mild Moderate Severe Totally Incapacitating

Please indicate which of the following areas are currently problematic for you. Check all that apply:

- | | |
|---|--|
| <input type="checkbox"/> Blackouts or temporary loss of memory | <input type="checkbox"/> Inability to concentrate while at school/work |
| <input type="checkbox"/> Insomnia (not being able to sleep) | <input type="checkbox"/> Crying spells |
| <input type="checkbox"/> Loss of appetite/increased appetite | <input type="checkbox"/> Feeling “on top of the world” |
| <input type="checkbox"/> Uncontrollable anxiety or worry | <input type="checkbox"/> Nightmares |
| <input type="checkbox"/> Lacking self-confidence | <input type="checkbox"/> Loss of interest in usual activities/lack of motivation |
| <input type="checkbox"/> Feeling fat | <input type="checkbox"/> Obsessions or compulsions with specific activities |
| <input type="checkbox"/> Eating and then vomiting to control weight | <input type="checkbox"/> Inability to control thoughts |
| <input type="checkbox"/> Excessive use of alcohol | <input type="checkbox"/> Feeling trapped in rooms/buildings |
| <input type="checkbox"/> Abuse of non-prescription drugs | <input type="checkbox"/> Hearing voices |
| <input type="checkbox"/> Getting into trouble at school/work | <input type="checkbox"/> Feeling that people are “out to get you” or that you are
being watched |
| <input type="checkbox"/> Feeling inferior to others | <input type="checkbox"/> Angry outbursts |
| <input type="checkbox"/> Under too much pressure and feeling stressed | <input type="checkbox"/> Excessive fear of specific places or objects |
| <input type="checkbox"/> Feeling down or unhappy/depressed mood | <input type="checkbox"/> Difficulty making friends |
| <input type="checkbox"/> Excessive anxiety or worry | <input type="checkbox"/> Difficulty maintaining friendships |
| <input type="checkbox"/> Feeling lonely | <input type="checkbox"/> Feeling as if you’d be better off dead |
| <input type="checkbox"/> Suspicious feelings toward other people | <input type="checkbox"/> Feeling manipulated or controlled by others |
| <input type="checkbox"/> Afraid of being on your own | <input type="checkbox"/> Difficulty making decisions |
| <input type="checkbox"/> Angry feelings | <input type="checkbox"/> Loss of interest in sexual relationships |
| <input type="checkbox"/> Concerns about finances | <input type="checkbox"/> Feeling sexually attracted to members of your own sex |
| <input type="checkbox"/> Feeling “numb” or cut off from emotions | <input type="checkbox"/> Feeling distant from God |
| <input type="checkbox"/> Concerns about physical health | |

- Concerns about emotional stability
- Tremors
- Delusions
- Hallucinations
- Hypersomnia (sleeping all the time)
- Not being able to say what you really think or feel

Other: _____

What would you like to gain from counseling? _____

How did you hear about us? _____

SPIRITUALITY

Do you believe in God? Yes No What is your religious preference? _____

Are you a member of a church? Yes No If yes, what church? _____

How much influence does your religion have on your day-to-day activity? A lot A moderate amount A little None

EMERGENCY CONTACT

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

Address: _____ City, State, Zip: _____

(Next of Kin – Other than Spouse)

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

Address: _____ City, State, Zip: _____

Stonebriar Psychiatric Services, P.A. Policies

OFFICE HOURS:

Monday through Thursday, 8:00 a.m. to 4:00 p.m. The office is closed major holidays and the week between Christmas Eve and New Year's.

APPOINTMENTS:

Sessions are by appointment only during regular office hours. Fees are based on time and sessions that go over will be charged accordingly. With the exception of emergency situations over which we have no control, our appointments begin promptly as scheduled. Your appointment time is reserved for you and you are encouraged to be certain that you arrive on time. If you are late, you will cut into your appointment time but will be responsible for the fee for the full time. **It is your responsibility to keep track of your appointments.** We make efforts to provide a courtesy reminder, but cannot guarantee that the reminder will be made or that it has been received. Reminders will normally be made via text message, the day prior to the appointment but this is not guaranteed and should not be relied upon to prevent your being charged for a missed appointment.

APPOINTMENT CHANGES/CANCELLATIONS:

Patients agree to notify the office of appointment changes or cancellations as far in advance of the scheduled time as possible to allow another patient to utilize the time. There is a required **minimum** notice of 24 business hours for individual sessions, a **minimum** notice of 48 hours for extended sessions (75, 90 and 120 minutes) and a **minimum** 1 week notice for scheduled intensives (over 120 minutes in one day) and all appointments during a holiday week, to avoid being charged for the time reserved. Monday appointments must be cancelled by the corresponding time on Thursday to avoid being a late cancel. If this minimum notice is not respected, patient will be charged the full fee for the time reserved. In the case of inclement weather, call the office first thing in the morning to see if the office has been closed. If not, and you are uncomfortable driving, you may have a phone session instead. In that case, you must call the office **prior to your appointment by at least 10 minutes and** give the receptionist your credit card information/authorization so you will be ready to be connected for your phone session. Receipts will be e-mailed to you. If you do not call or come to your appointment, you will be charged.

If, for any reason, SPS must cancel an appointment, the patient will be advised as soon as possible.

FEES AND PAYMENT:

Payment is required at or before the time of the appointment. We provide coded receipts for patients who wish to file for reimbursement on their own, but we do not deal directly with health insurance companies, nor do we complete or sign forms, provide treatment plans, or forward records. Depending on your individual coverage, you may qualify for benefits. You will need to check with your insurance carrier for details about your specific coverage. Please keep the documentation given to you at time of treatment. Additional copies will incur a fee to research and photocopy receipts. You may also use this documentation to file your claim if you participate in a cafeteria or medical reimbursement plan at your place of employment. There is a \$ 35.00 charge for bounced checks and a \$ 5.00 charge for declined credit cards.

EMERGENCY CALLS:

During office hours, for calls that are urgent but not life threatening, please speak to the staff. For those that represent a life threatening emergency, always call 911 immediately or go to your local emergency room. When you are expecting a return call and your telephone **Caller ID** does not accept "Private or Blocked Calls", we will not be able to return your phone call. Please **unblock** your **Caller ID** prior to placing your call. Fees will be charged based on time required. Additional fees apply to contact outside of office hours.

REPORTS, LETTERS, RECORDS, DISABILITY FORMS

Welcome to Stonebriar Psychiatric Services, PA.

Welcome! We are happy to have you or your family member as a patient and will do everything within our professional capacity to make the treatment as productive as possible.

The specifics of the treatment goals and the steps to achieve these goals will be discussed at the first appointment. Your participation and understanding of the treatment goals is essential for the best benefit of therapy. If you ever have questions about the nature of the treatment or any other aspect of your care, please do not hesitate to ask.

CONFIDENTIALITY and AUTHORIZATION TO RELEASE INFORMATION

It is understood that all information between patient and psychiatrist/therapist is held strictly confidential, and the psychiatrist/therapist will not release any information about therapy unless permitted by law or:

1. It is agreed upon in writing and complies with State Laws.
2. The patient presents an imminent danger to self.
3. The patient presents an imminent danger to others.
4. Child/elder abuse/neglect is suspected.
5. As necessary for continuity of care.
6. If a judge determines that our discussions are not confidential, a judge may request specific information.
7. As requested by a court appointed attorney for a child involved in court proceedings.

It is understood that in cases #2, #3, and #4, the psychiatrist/therapist is required by law to inform potential victims and legal authorities so that protective measures can be taken. If I participate in group counseling, I agree not to discuss any details of the group outside of the counseling sessions. Stonebriar Psychiatric Services, PA follows the “minimum necessary” rule when releasing information.

PATIENT CONSENT TO RELEASE OF INFORMATION

I consent to information release about my case (or my child’s case) with the referral source and other co-treating health care providers and facilities for the purposes of treatment. I authorize that Stonebriar Psychiatric Services, PA providers may disclose any information, including drug and alcohol abuse and HIV status, regarding my or my child’s treatment for purposes of continuity of care. I know I have the right to revoke this authorization which must be in writing and given to my provider. I understand that if I revoke this authorization, my providers may determine that treatment cannot be effective without continuity of care, and may elect to transfer my care to another provider. This Authorization is valid as long as I am treated at Stonebriar Psychiatric Services, PA, or by my revoking the authorization.

Patient/Legal Representative Signature

Date

Witness

Date

Stonebriar Psychiatric Services, P.A.
Payment of Services and Missed Appointment Agreement Form

Our services are provided by appointment only and when a patient schedules an appointment, time is reserved for that patient and not available to others. Missed appointments, as well as those cancelled with less than a **minimum 24 business hours**' notice (48 hour **minimum** on extended sessions and 1 full week **minimum** notice on intensives, which are appointments including over 120 minutes scheduled in one day) will be charged the fee for the visit.

This same credit card will be used in the event of a phone session or other service for which patient is not in the office (prescription refills, reports, forms, letters, phone calls, phone calls to outside therapists, etc), as well as to cover checks returned for nonsufficient funds (NSF).

Patient Name: _____

The fee for the visit will be charged on the day of the missed appointment (or day of the late-cancel) to the following credit card:

 Visa **MasterCard** **American Express** **Discover**

Credit Card #: _____

Expiration Date: _____

Name as it appears on Card: _____

Security Code from back of card: _____

I, _____, cardholder for the credit card listed above, understand and agree that if I or my family member do not show up for a scheduled appointment or if I cancel a scheduled appointment with less than a minimum **24 business hours**' notice (48 hour minimum *business hours*' notice extended sessions) **and 1 full week** minimum *business hours*' **notice on intensives, which are appointments including over 120 minutes scheduled in one day**), the above named credit card will be charged for the full amount of the reserved session. Additional fees as listed above will also be charged.

Cardholder Signature _____ **Date** _____

Printed Name _____

Billing Address: _____

City: _____ Zip: _____ Day Phone _____

- ***To qualify for a timely cancellation on individual Monday appointments, the cancellation must be received by the corresponding time on the previous Thursday. Cancellations immediately preceding a holiday break must occur before the corresponding time on the last business day before the holiday. Voice mail and e-mail cancellations do not qualify as they can not be guaranteed as received.***

ADDITIONAL AUTHORIZATION

Use this authorization to charge services for all my family member(s) who are also seen at the office. _____ (initial your approval) Otherwise a separate form will be required for each individual.

All Family Members _____ (initial your approval)

Specific family member(s)

_____ (name) _____ (initial your approval)

_____ (name) _____ (initial your approval)

_____ (name) _____ (initial your approval)

_____ (name) _____ (initial your approval)

Stonebriar Psychiatric Services, PA

CAGE and SCOFF screens

	Yes	No
1. Have you ever felt you ought to cut down on your drinking?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have people annoyed you by criticizing your drinking?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever felt bad or guilty about your drinking?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever had an “eye-opener” to steady nerves in AM?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you used substances more than intended this year?	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you make yourself SICK because you feel uncomfortably full?	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you worry you have lost CONTROL over how much you eat?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you recently lost more than ONE STONE (15 pounds) in a three-month period?	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you believe yourself to be FAT when others say you are too thin?	<input type="checkbox"/>	<input type="checkbox"/>
10. Would you say that FOOD dominates your life?	<input type="checkbox"/>	<input type="checkbox"/>

Stonebriar Psychiatric Services, PA Mood Disorder Questionnaire

- | | | YES | NO |
|----|---|--------------------------|--------------------------|
| 1. | Has there ever been a period of time when you were not your usual self and ... | | |
| | ... you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble? | <input type="checkbox"/> | <input type="checkbox"/> |
| | ... you were so irritable that you shouted at people or started fights or arguments? | <input type="checkbox"/> | <input type="checkbox"/> |
| | ... you felt much more self-confident than usual? | <input type="checkbox"/> | <input type="checkbox"/> |
| | ... you got much less sleep than usual and found that you didn't really miss it? | <input type="checkbox"/> | <input type="checkbox"/> |
| | ... you were more talkative or spoke much faster than usual? | <input type="checkbox"/> | <input type="checkbox"/> |
| | ... thoughts raced through your head or you couldn't slow your mind down? | <input type="checkbox"/> | <input type="checkbox"/> |
| | ... you were so easily distracted by things around you that you had trouble concentrating or staying on track? | <input type="checkbox"/> | <input type="checkbox"/> |
| | ... you had much more energy than usual? | <input type="checkbox"/> | <input type="checkbox"/> |
| | ... you were much more active or did many more things than usual? | <input type="checkbox"/> | <input type="checkbox"/> |
| | ... you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night? | <input type="checkbox"/> | <input type="checkbox"/> |
| | ... you were much more interested in sex than usual? | <input type="checkbox"/> | <input type="checkbox"/> |
| | ... you did things that were unusual for you or that other people might have thought were excessive, foolish or risky? | <input type="checkbox"/> | <input type="checkbox"/> |
| | ... spending money got you or your family in trouble? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. | If you checked YES to more than one of the above, have several of these ever happened during the same period of time? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. | How much of a problem did any of these cause you – like being able to work; having family, money or legal troubles; getting into arguments or fights? | | |
| | <input type="checkbox"/> No problem <input type="checkbox"/> Minor problem <input type="checkbox"/> Moderate problem <input type="checkbox"/> Serious problem | | |
| 4. | Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. | Has a health professional told you that you have manic-depressive illness or bipolar disorder | <input type="checkbox"/> | <input type="checkbox"/> |

Stonebriar Psychiatric Services, PA

Adult ADHD Self-Report Scale Symptom Checklist

Patient Name					
Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please turn in this completed checklist when you are finished.	Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?					
3. How often do you have problems remembering appointments or obligations?					
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?					
Part A					
7. How often do you make careless mistakes when you have to work on a boring or difficult project?					
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
10. How often do you misplace or have difficulty finding things at home or at work?					
11. How often are you distracted by activity or noise around you?					
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?					
13. How often do you feel restless or fidgety?					
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?					
15. How often do you find yourself talking too much when you are in social situation					
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish themselves?					
17. How often do you have difficulty waiting your turn in situations when turn taking is required?					
18. How often do you interrupt others when they are busy?					

DIRECTIONS: - Select one of the four words in each line that is most like you and place an X in front of that word. Continue through all forty lines. Be sure each numbered line is marked, and that each line has **only one** mark.

STRENGTHS

- | | | | |
|-------------------------|----------------------|------------------|-------------------|
| 1. ___ Adventurous | ___ Adaptable | ___ Animated | ___ Analytical |
| 2. ___ Persistent | ___ Playful | ___ Persuasive | ___ Peaceful |
| 3. ___ Submissive | ___ Self-sacrificing | ___ Sociable | ___ Strong-willed |
| 4. ___ Considerate | ___ Controlled | ___ Competitive | ___ Convincing |
| 5. ___ Refreshing | ___ Respectful | ___ Reserved | ___ Resourceful |
| 6. ___ Satisfied | ___ Sensitive | ___ Self-reliant | ___ Spirited |
| 7. ___ Planner | ___ Patient | ___ Positive | ___ Promoter |
| 8. ___ Sure | ___ Spontaneous | ___ Scheduled | ___ Shy |
| 9. ___ Orderly | ___ Obliging | ___ Outspoken | ___ Optimistic |
| 10. ___ Friendly | ___ Faithful | ___ Funny | ___ Forceful |
| 11. ___ Daring | ___ Delightful | ___ Diplomatic | ___ Detailed |
| 12. ___ Cheerful | ___ Consistent | ___ Cultured | ___ Confident |
| 13. ___ Idealistic | ___ Independent | ___ Inoffensive | ___ Inspiring |
| 14. ___ Demonstrative | ___ Decisive | ___ Dry humor | ___ Deep |
| 15. ___ Mediator | ___ Musical | ___ Mover | ___ Mixes easily |
| 16. ___ Thoughtful | ___ Tenacious | ___ Talker | ___ Tolerant |
| 17. ___ Listener | ___ Loyal | ___ Leader | ___ Lively |
| 18. ___ Contented | ___ Chief | ___ Chartmaker | ___ Cute |
| 19. ___ Perfectionistic | ___ Permissive | ___ Productive | ___ Popular |
| 20. ___ Bouncy | ___ Bold | ___ Behaved | ___ Balanced |

WEAKNESSES

- | | | | |
|------------------------|-----------------------|--------------------|--------------------|
| 21. ___ Blank | ___ Bashful | ___ Brassy | ___ Bossy |
| 22. ___ Undisciplined | ___ Unsympathetic | ___ Unenthusiastic | ___ Unforgiving |
| 23. ___ Reticent | ___ Resentful | ___ Resistant | ___ Repetitious |
| 24. ___ Fussy | ___ Fearful | ___ Forgetful | ___ Frank |
| 25. ___ Impatient | ___ Insecure | ___ Indecisive | ___ Interrupts |
| 26. ___ Unpopular | ___ Uninvolved | ___ Unpredictable | ___ Unaffectionate |
| 27. ___ Headstrong | ___ Haphazard | ___ Hard to please | ___ Hesitant |
| 28. ___ Plain | ___ Pessimistic | ___ Proud | ___ Permissive |
| 29. ___ Angered easily | ___ Aimless | ___ Argumentative | ___ Alienated |
| 30. ___ Naïve | ___ Negative attitude | ___ Nervy | ___ Nonchalant |
| 31. ___ Worrier | ___ Withdrawn | ___ Workaholic | ___ Wants credit |
| 32. ___ Too sensitive | ___ Tactless | ___ Timid | ___ Talkative |
| 33. ___ Doubtful | ___ Disorganized | ___ Domineering | ___ Depressed |
| 34. ___ Inconsistent | ___ Introvert | ___ Intolerant | ___ Indifferent |
| 35. ___ Messy | ___ Moody | ___ Mumbles | ___ Manipulative |
| 36. ___ Slow | ___ Stubborn | ___ Show-off | ___ Skeptical |
| 37. ___ Loner | ___ Lord over | ___ Lazy | ___ Loud |
| 38. ___ Sluggish | ___ Suspicious | ___ Short-tempered | ___ Scatterbrained |
| 39. ___ Revengeful | ___ Restless | ___ Reluctant | ___ Rash |
| 40. ___ Compromising | ___ Critical | ___ Crafty | ___ Changeable |