DAVID L. FOGELSON, M.D., Inc.
Psychiatry
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Welcome to our office!

Thank you for making an appointment with Dr. Fogelson. Attached is an important questionnaire for you to fill out and bring with you to your appointment. Please be sure to fill out all pages. Directions and a map indicating the location of the office may be found on this website.

We want you to understand our medical specialty and to feel comfortable in our office. The pamphlets on this website may answer some questions for you. Other areas of this website explain office procedures. Please feel free to ask Dr. Fogelson or myself any questions that may remain unanswered.

Dr. Fogelson received his medical degree from Harvard Medical School and his graduate training in Psychiatry from U.C.L.A. He is a Clinical Professor at the U.C.L.A. Neuro-Psychiatric Institute. Dr. Fogelson is a general psychiatrist for adults. He specializes in medication treatments and psychotherapy.

Dr. Fogelson and I look forward to meeting you.

Sincerely,

Administrative Coordinator

P.S. If the doors to the building are locked, please use the breezeway entrance along the side of the building. You can let yourself into the building by pressing, "start, #, 3325

David L. Fogelson, M.D., Inc.
Consent for Evaluation or Treatment

Please take a moment to review some information to which you are entitled before receiving psychiatric services.

Any information you disclose will be maintained in the strictest confidence, unless you specifically authorize its release, or unless its release is required by law or professional standards of practice. In particular, your right to confidentiality may not be maintained if you are an immediate danger to yourself or to someone else, and steps must be taken to assure your own or another's safety. Also, any clinician hearing about domestic violence from a patient or that a child or elder is being or has been physically or psychologically abused is required by law to report this information to a designated agency. If it is necessary to disclose some information you have provided, to anyone else, this will be discussed with you.

All outpatient visits must be paid for at the time of the visit. Dr. Fogelson is not a provider for any of the insurance networks. At the time of your outpatient visit, you will be provided with an insurance statement to submit to your insurance company. We cannot accept responsibility for negotiating claims with insurance companies or other persons. You are responsible for payment of your medical care regardless of the status of your claim. Any other financial arrangement must be made with us prior to service.

It is important for your continued medical care that you have routine follow up appointments so that the doctor can monitor your care. Therefore, if you have not returned to see the doctor by three months after the date of recommended return to the office, we will consider the doctor patient relationship terminated and no prescription refills will be granted after this period.

Any outstanding bills will be rebilled monthly. If payment is not received after two successive billings, your account may be sent to a collection service. Should you need to cancel a session, please do so at least **48 business hours** in advance. Otherwise you will be charged at your regular rate for the cancelled session. Under circumstances where a party other than the patient is responsible for payment, that party must sign a separate agreement guaranteeing payment of the bill.

There is a returned check charge of $20.00.

I agree in the event of non-payment to bear the cost of collection and/or court costs and legal fees should this be required.

I have read and understood the foregoing, and I consent to this evaluation or treatment.

_____ _____

Signature *Date*

Office Fees:

Appointment	Fee
Payment Methods Accepted:	Visa, Mastercard, Discover, Check, Cash
Evaluation 90 minutes	$750
Medication Follow Up 30 minutes	$250
Medication Follow Up/Therapy 45 minutes	$375
Medication Follow Up/Therapy 60 minutes	$500

NEW PATIENT INFORMATION RECORD (PLEASE WRITE LEGIBLY)

First Name	**Last Name**			Referred By
Driver's License Number	Marital Status	Date of Birth __/__/__	Age	Social Security Number ___ __ ____
Street Address	City		State	Zip Code
Home Phone	Cell Phone			Email
Employed By or Retired From	Occupation (Or Student)		How long?	Business Phone
Employer's Street Address	City		State	Zip Code
Person Responsible for Payment	City and State		Zip Code	Home Phone

Referring Physician	**Referring Therapist**
Address	Address
Phone	Phone

Person to Contact in Case of Emergency Name		
Relationship	Home Phone	Cell Phone
Address		

TO BE FILLED OUT BY PATIENT (Please complete the following to the best of your ability)

A. Personal Medical History

1. Do you receive regular medical care from a physician or clinic?

   YES **NO**

2. If yes, please provide the following information:

   Name of Physician or Clinic: _____

   Phone: ( )_____

   Address: _____

3. Have you ever had any of the following illnesses?

Please make a X for each illness	**NO**	**YES**	*Please make a X for each illness*	**NO**	**YES**
High Blood Pressure			Migraine Headaches		
Diabetes			Peptic Ulcer (Stomach Ulcer)		
Cancer			Colitis		
Thyroid Disease			Meningitis or Encephalitis		
Other Hormone Problem			Tuberculosis		
Alcoholism			Stroke		
Gonorrhea			Rheumatic Fever		
Syphilis			Asthma		
Epilepsy			Birth Defects		

4. Have you had any other disease? **NO** **YES** If yes, explain: _____

_____

_____

_____

5. What is your current weight? (Estimate if you do not know exactly) _____ lbs

6. What is the most you have ever weighed? _____ lbs When? _____

7. Can you explain any recent weight loss or weight gain? _____

_____

_____

8. Have you ever had to be hospitalized? **NO** **YES**
   If yes, complete the following:

Year	**Doctor's Name**	**Name of Hospital**	**Reason**
_____	_____	_____	_____
_____	_____	_____	_____

9. Have you ever had surgery or been advised to have surgery? **NO** **YES**
If yes, complete the following:

Year	**Doctor's Name**	**Name of Hospital**	**Name of Operation/Procedure**

10. Have you ever had any injuries?

	NO	**YES**	**How did it happen?**
Head Injury			
Concussion (Ever been knocked unconscious)			
Food, Chemical, Drug Poisoning			
Broken Bones			
Severe Cuts or Lacerations			
Other:			

11. Do you have any allergies?

	NO	**YES**	**How are you affected?**
Hay Fever			
Penicillin			
Other Medication:			

12. Have you recently had any of the following tests?

	NO	**YES**	**WHEN**	**WHERE**	**RESULTS**
Physical Exam					
Blood Tests					
Chest X-Ray					
TB Skin Test (PPD)					
Electrocardiogram (EKG)					
Brain Scan or EMI					
EEG					

13. Are you in the habit of using any of the following items?

	Amount Currently Using	Most Ever Used
Coffee (Cups/Day)		
Cigarettes (Packs/Day)		
Alcohol (Amounts/Types of Alcohol Used Daily)		
Marijuana (Joints/Day)		
Vitamins		
Sleeping Pills		
Glue or Paint Inhalation		
Aspirin		
Laxatives		

14. Are you currently on any medication? **NO** **YES**
If yes, please give name and dosage: _____

_____

_____

_____

_____

C. Personal Psychiatric History

1. Have you ever received any previous psychiatric or psychological evaluation or treatment? **NO** **YES**

If yes, complete the following:

Year	**Doctor, Clinic, Hospital**	**Reason**	**Medication Used (if any)**
_____	_____	_____	_____
_____	_____	_____	_____

2. Have you ever attempted suicide in the past? **NO** **YES**

If yes, complete the following:

Year	**How did you attempt suicide?**	**What happened?**
_____	_____	_____
_____	_____	_____
_____	_____	_____

D. Family History:

	Father	Mother	Brother			Sister			Spouse	Children					
Age (if deceased give date and age at death)			1	2	3	1	2	3		1	2	3	4	5	6
Cancer															
Tuberculosis															
Diabetes															
High Blood Pressure															
Stroke															
Heart Attack or Heart Trouble															
Epilepsy or Convulsions															
Nervous Breakdown or Severe Depression															
Alcoholism															
Suicide or Suicide Attempt															
Drug Abuse															
Birth Defects or Genetic Disorders															
Thyroid Problem															
Other Hormone Problem															
Migraine Headaches															

E. Review of Your Current Health:

1. Do you have?

	NO	YES		NO	YES
Lumps anywhere			Unusual excessive thirst		
Double vision or poor vision			Urine problems, blood in urine		
Difficulty hearing			Indigestion, gas, heartburn		
Fainting spells, blackout spells			Stomach pain or stomach ulcer		
Convulsions			Diarrhea		
Paralysis			Constipation		
Dizziness			Vomiting, vomiting blood		
Headaches			Blood in stool		
Thyroid problem goiter			Change in appetite or eating habits		
Skin problem			Trouble sleeping		
Cough or wheeze			Sexual problems		
Chest pain			Weight loss or weight gain		
Spitting up blood			Depression		
Shortness of breath at night or with exercise			Suicidal thoughts		
Palpitation or heart fluttering			Problems with memory, thinking or concentration		
Swelling of hands or feet			Weakness or tiredness		
Visual hallucinations			Joint pain		
Fever, sweats, or chills					

Please describe or explain any of the positive answers above: _____

_____

_____

_____

_____

2. For Females Only:

   a. Date your last menstrual period began: _____

   b. Number of pregnancies: _____

   c. Number of children born alive: _____

   d. Number of therapeutic abortions: _____

   e. Number of miscarriages or stillbirths: _____

   f. Have you had a Pap smear within the last year? **NO** **YES**

   g. Do you use any contraceptive method? **NO** **YES** If yes, what? _____

   h. Do you examine your breasts for lumps? **NO** **YES**

F. Have you ever used any of the following drugs or medications? *(circle the ones used)*

	NO	YES	WHEN	HOW MUCH?
Dilantin, L-Dopa, Cogentin, Artane				
Valium, Serax, Dalmane, Tranxene, Librium				
Sinequan, Tofranil, Elavil, Meprobamate				
Thorazine, Mellaril, Stelazine, Navane, Haldol				
Prolixin Injection, Loxitane, Moban, Serentil				
Phenobarbital, Seconal, Tuinal, Other Barbiturates				
Amphetamines, Other Stimulants, Cocaine				
Heroin, Codein, Methadone, Percodan, Dilaudid Talwin, Darvon, Demerol				
Quaaludes, Placidyl, Other Sedatives				
PCP				
LSD, Mushrooms, Psilocybin, Other Hallucinogens				
Other				

G. Have you ever taken any of the following medications?

Brand Name (generic)	NO	YES	*Brand Name (generic)*	NO	YES
Abilify (aripiprazole)			Luvox (fluvoxamine)		
Adderall (amphetamine salts)			Lyrica (pregabalin)		
Ambien (zolpidem)			Marplan (isocarboxazid)		
Anafranil (clomipramine)			Nardil (phenelzine)		
Aplenzin (bupropion)			Neurontin (gabapentin)		
Asendin (amoxapine)			Norpramin/ Pertofrane (desipramine)		
Ativan (lorazepam)			Nuvigil (armodafinil)		
Brintellix (vortioxetine)			Pamelor (nortriptyline)		
Buspar (buspirone)			Parnate (tranylcypromine)		
Celexa (citalopram)			Paxil (paroxetine)		
Clozapine (clozaril)			Provigil (modafinil)		
Concerta (methylphenidate)			Prozac (fluoxetine)		
Cymbalta (duloxetine)			Remeron (mirtazapine)		
Cytomel (liothyronine)			Risperdal (risperidone)		
Depakote/Depakane (valproic acid)			Ritalin (methylphenidate)		
Desyrel (trazodone)			Saphris (asenapine)		
Effexor (venlafaxine)			Seroquel (quetiapine)		

Fanapt (iloperidone)			Serzone (nefazodone)		
Fetzima (levomilnacipran)			Strattera (atomoxetine)		
Geodon (ziprasidone)			Suboxone (buprenorphine/ naloxone)		
Intuniv (guanfacine)			Tegretol (carbamazepine)		
Invega (paliperidone)			Viibryd (vilazodone)		
Klonopin (clonazepam)			Vyvanse (lisdexamfetamine)		
Lamictal (lamotrigine)			Wellbutrin (buproprion)		
Latuda (lurasidone)			Xanax (alprazolam)		
Lexapro (escitalopram)			Zoloft (sertraline)		
Lithobid (lithium carbonate)			Zyprexa (olanzapine)		
Lunesta (eszopiclone)					

H. Do you now or in the past:

	NO	YES
Snore		
Jerk your arms/legs while asleep		
Gasp for breath during sleep		
Have creeping or crawling leg sensations		
Fall asleep suddenly during the day		
Wet the bed		
Walk or talk in your sleep		

I. Have you ever:

	NO	YES
Binged on food uncontrollably		
Forced yourself to vomit food		
Used laxatives, water pills, diet pills, enemas or ipecac to lose weight		
Lost so much weight you stopped having your menstrual period		
Been told you are bulimic or anorexic		

J. Do you ever have:

	NO	YES
Repetitive, unwanted thoughts		
Irresistible urges to check, count, clean, touch or say things repeatedly		
Spasms, twitches or tics		

K. While in school, did you:

	NO	YES
Have trouble sitting in class		
Have trouble concentrating on school work		
Have trouble getting along with schoolmates		
Have anxiety about going to school		
Get left back or expelled		
Attend special education classes		
Have a stutter, lisp		
Run away from home		

L. Have you ever experienced:

	NO	YES
Hearing voices when no one is around		
Watching things disappear, or change shape, color or position when this should not have occurred		
Unusual (rotten or fragment) smells without anything to account for it		
Feelings of being touched without anyone or anything actually touching you		
A sense of detachment from your surroundings		
A feeling of unreality		
Periods of excessive energy, racing thoughts, diminished need for sleep, euphoria, spending sprees, increased sex drive, feelings of power		

M. Have you ever had:

	NO	YES
Hepatitis		
Kidney disease/stones		
Glaucoma		
Blood Transfusions		
Lyme Disease		

N. Have any of your family (parents, brothers/sisters, children, aunts/uncles, grandparents) had the following:

	NO	YES
Manic-depressive disorder or depression		
Schizophrenia		
Obsessive-compulsive disorder		
Panic Attacks		
Autism		
Epilepsy		
Tourette's disease		
Alzheimer's disease		
Huntington's disease		
Wilson's disease		
Parkinson's disease		
Porphyria		
Anorexia or Bulimia		

O. Have you ever been:

	NO	YES
In the military		
If yes, dishonorably discharged		
Arrested for any reason		
Injured in an accident or war		
Subject to physical, sexual or verbal abuse		
Involved in a personal injury, or workman's compensation or medical malpractice lawsuit		
To your knowledge, have you ever been exposed to any toxic chemicals		

P. Have you ever had the experience of:

	NO	YES
Finding yourself in a place and having no idea how you got there		
Minutes, hours or days having gone by without any memory of what has happened during that time		
Having no memory for some important events in your life (for example, a graduation, wedding, death)		

Q. Do you ever have irresistible urges to:

	NO	YES
Hurt, attack or kill someone		
Throw, break, destroy property		
Steal objects you don't need for personal use or monetary value		
Gamble, whether you can afford to or not		
Deliberately set fires		
Deliberately pull your hair out		

R. Recent stressful life events (in last 2 years):

	NO	YES		NO	YES
Marriage or engagement			Personal injury or illness		
Separation or divorce			Sexual difficulties		
Breakup of important relationship			Changes in school, work		
Death of close family, friend			Changes in residence		
Child left home			Financial disorder		
Bad health of family, friend			Legal difficulties		

Instructions

These questions are about the kind of person you are generally are-that is, how you have usually felt or behaved over the past several years. Circle "YES" if the question completely or mostly applies to you, or circle "NO" if it does not apply to you. If you do not understand a question or are not sure of your answer, leave it blank.

1. Have you avoided jobs or tasks that involved having to deal with a lot of people?	NO	YES	PQ4
2. Do you avoid getting involved with people unless you are certain they will like you?	NO	YES	PQ5
3. Do you find it hard to be "open" even with people you are close to?	NO	YES	PQ6
4. Do you often worry about being criticized or rejected in social situations?	NO	YES	PQ7
5. Are you usually quiet when you meet new people?	NO	YES	PQ8
6. Do you believe that you're not good, as smart, or as attractive as most other people?	NO	YES	PQ9
7. Are you afraid to try new things?	NO	YES	PQ10
8. Do you need a lot of advice or reassurance from others before you can make everyday decisions- like what to wear or what to order in a restaurant?	NO	YES	PQ11
9. Do you depend on other people to handle important areas in your life such as finances, child care, or living arrangements?	NO	YES	PQ12
10. Do you find it hard to disagree with people even when you think they are wrong?	NO	YES	PQ13
11. Do you find it hard to start or work on tasks when there is no one to help you?	NO	YES	PQ14
12. Have you often volunteered to do things that are unpleasant?	NO	YES	PQ15
13. Do you usually feel uncomfortable when you are by yourself?	NO	YES	PQ16

14. When a close relationship ends, do you feel you immediately have to find someone else to take care of you?	NO	YES	PQ17
15. Do you worry a lot about being left alone to take care of yourself?	NO	YES	PQ18
16. Are you the kind of person who focuses on details, order, and organization or likes to make lists and schedules?	NO	YES	PQ19
17. Do you have trouble finishing jobs because you spend so much time trying to get things exactly right?	NO	YES	PQ20
18. Do you or other people feel that you are so devoted to work (or school) tha t you have no time left for anyone else or for just having fun?	NO	YES	PQ21
19. Do you have very high standards about what is right and what is wrong?	NO	YES	PQ22
20. Do you have trouble throwing things out because they might come in handy some day?	NO	YES	PQ23
21. Is it hard for you to let other people help you unless they agree to do things exactly the way you want?	NO	YES	PQ24
22. Is it hard for you to spend money on yourself and other people even when you have enough?	NO	YES	PQ25
23. Are you often so sure you are right that it doesn't matter what other people say?	NO	YES	PQ26
24. Have other people told you that are stubborn or rigid?	NO	YES	PQ27
25. When someone asks you to do something that you don't want to do, do you say "yes" but then work slowly or do a bad job?	NO	YES	PQ28
26. If you don't want to do something, do you often just "forget" to do it?	NO	YES	PQ29
27. Do you often feel that other people don't understand you, or don't appreciate how much you do?	NO	YES	PQ30
28. Are you often grumpy and likely to get into arguments?	NO	YES	PQ31

29. Have you found that most of your bosses, teachers, supervisors, doctors, and others who are supposed to know what they are doing really don't?	NO	YES	PQ32
30. Do you often think that it's not fair that other people have more than you do?	NO	YES	PQ33
31. Do you often complain that more than your share of bad things have happened to you?	NO	YES	PQ34
32. Do you often angrily refuse to do what others want and then later feel bad and apologize?	NO	YES	PQ35
33. Do you usually feel unhappy or that life is no fun?	NO	YES	PQ36
34. Do you believe that you are basically an inadequate person and often don't feel good about yourself?	NO	YES	PQ37
35. Do you often put yourself down?	NO	YES	PQ38
36. Do you keep thinking about bad things that have happened in the past or worry about bad things that might happen in the future?	NO	YES	PQ39
37. Do you often judge others harshly and easily find fault with them?	NO	YES	PQ40
38. Do you think that most people are basically no good?	NO	YES	PQ41
39. Do you almost always expect things to turn out badly?	NO	YES	PQ42
40. Do you often feel guilty about things you have or haven't done?	NO	YES	PQ43
41. Do you often have to keep an eye out to stop people from using you or hurting you?	NO	YES	PQ44
42. Do you spend a lot of time wondering if you can trust your friends or the people you work with?	NO	YES	PQ45
43. Do you find that it is best not to let other people know much about you because they will use it against you?	NO	YES	PQ46
44. Do you often detect hidden threats or insults in things people say or do?	NO	YES	PQ47

45. Are you the kind of person who holds grudges or takes a long time to forgive people who have insulted or slighted you?	NO	YES	PQ48
46. Are there many people you can't forgive because they did or said something to you a long time ago?	NO	YES	PQ49
47. Do you often get angry or lash out when someone criticizes or insults you in some way?	NO	YES	PQ50
48. Have you often suspected that your spouse or partner has been unfaithful?	NO	YES	PQ51
49. When you are out in public and see people talking, do you often feel that they are talking about you?	NO	YES	PQ52
50. Do you often get the feeling that things that have no special meaning to most people are really meant to give you a message?	NO	YES	PQ53
51. When you are around people, do you often get the feeling that you are being watched or stared at?	NO	YES	PQ54
52. Have you ever felt that you could make things happen just by making a wish or thinking about them?	NO	YES	PQ55
53. Have you had personal experiences with the supernatural?	NO	YES	PQ56
54. Do you believe that you have a "sixth sense" that allows you to know and predict things that others can't?	NO	YES	PQ57
55. Does it often seem that objects or shadows are really people or animals or that noises are actually people's voices?	NO	YES	PQ58
56. Have you had the sense that some person or force is around you, even though you cannot see anyone?	NO	YES	PQ59
57. Do you often see auras or energy fields around people?	NO	YES	PQ60
58. Are there very few people that you're really close to outside of your immediate family?	NO	YES	PQ61
59. Do you often feel nervous when you are with othe r people?	NO	YES	PQ62
60. Is it NOT important to you whether you have any close relationships?	NO	YES	PQ63

61. Would you almost always rather do things alone than with other people?	NO	YES	PQ64
62. Could you be content without ever being sexually involved with anyone?	NO	YES	PQ65
63. Are there really very few things that give you pleasure?	NO	YES	PQ66
64. Does it NOT matter to you what people think of you?	NO	YES	PQ67
65. Do you find that nothing makes you very happy or very sad?	NO	YES	PQ68
66. Do you like to be the center of attention?	NO	YES	PQ69
67. Do you flirt a lot?	NO	YES	PQ70
68. Do you often find yourself "coming on" to people?	NO	YES	PQ71
69. Do you try to draw attention to yourself by the way you dress or look?	NO	YES	PQ72
70. Do you often make a point of being dramatic and colorful?	NO	YES	PQ73
71. Do you often change your mind about things depending on the people you're with or what you ha ve just read or seen on TV?	NO	YES	PQ74
72. Do you have lots of friends that you are very close to?	NO	YES	PQ75
73. Do people often fail to appreciate your very special talents or accomplishments?	NO	YES	PQ76
74. Have people told you that you have too high an opinion of yourself?	NO	YES	PQ77
75. Do you think a lot about the power, fame, or recognition that will be yours someday?	NO	YES	PQ78
76. Do you think a lot about the perfect romance that will be yours someday?	NO	YES	PQ79
77. When you have a problem, do you almost always insist on seeing the top person?	NO	YES	PQ80

78. Do you feel it is important to spend time with people who are special or influential?	NO	YES	PQ81
79. Is it very important to you that people pay attention to you or admire you in some way?	NO	YES	PQ82
80. Do you think that it's not necessary to follow certain rules or social conventions when they get in your way?	NO	YES	PQ83
81. Do you feel that you are the kind of person who deserves special treatment?	NO	YES	PQ84
82. Do you often find it necessary to step on a few toes to get what you want?	NO	YES	PQ85
83. Do you often have to put your needs above other people's?	NO	YES	PQ86
84. Do you often expect other people to do what you ask without question because of who you are?	NO	YES	PQ87
85. Are you NOT really interested in other people's problems or feelings?	NO	YES	PQ88
86. Have people complained to you that you don't listen to them or care about their feelings?	NO	YES	PQ89
87. Are you often envious of others?	NO	YES	PQ90
88. Do you feel that others are often envious of you?	NO	YES	PQ91
89. Do you find that there are very few people that are worth your time and attention?	NO	YES	PQ92
90. Have you often become frantic when you thought that someone you really cared about was going to leave you?	NO	YES	PQ93
91. Do your relationships with people you really care about have lots of extreme ups and downs?	NO	YES	PQ94
92. Have you all of a sudden changed your sense of you are and where you are headed?	NO	YES	PQ95
93. Does your sense of who you are often change dramatically?	NO	YES	PQ96

94. Are you different with different people or in different situations, so that you sometimes don't know who you really are?	NO	YES	PQ97
95. Have there been lots of sudden changes in your goals, career plans, religious belief, and so on?	NO	YES	PQ98
96. Have you often done things impulsively?	NO	YES	PQ99
97. Have you tried to hurt or kill yourself or threatened to do so?	NO	YES	PQ100
98. Have you ever cut, burned, or scratched yourself on purpose?	NO	YES	PQ101
99. Do you have a lot of sudden mood changes?	NO	YES	PQ102
100. Do you often feel empty inside?	NO	YES	PQ103
101. Do you often have temper outbursts or get so angry that you lose control?	NO	YES	PQ104
102. Do you hit people or throw things when you get angry?	NO	YES	PQ105
103. Do even little things get you very angry?	NO	YES	PQ106
104. When you are under a lot of stress, do you get suspicious of other people or feel especially spaced out?	NO	YES	PQ107
105. Before you were 15, would you bully or threaten other kids?	NO	YES	PQ108
106. Before you were 15, would you start fights?	NO	YES	PQ109
107. Before you were 15, did you hurt or threaten someone with a weapon, like a bat, brick, broken bottle, knife, or gun?	NO	YES	PQ110
108. Before you were 15, did you deliberately torture someone or cause someone physical pain and suffering?	NO	YES	PQ111
109. Before you were 15, did you torture or hurt animals on purpose?	NO	YES	PQ112
110. Before you were 15, did you rob, mug, or forcibly take something from someone by threatening him or her?	NO	YES	PQ113

111. Before you were 15, did you force someone to have sex with you, to get undressed in front of you, or touch you sexually.	NO	YES	PQ114
112. Before you were 15, did you set fires?	NO	YES	PQ115
113. Before you were 15, did you deliberately destroy things that weren't yours?	NO	YES	PQ116
114. Before you were 15, did you break into houses, other buildings, or cars?	NO	YES	PQ117
115. Before you were 15, did you lie a lot or "con" other people?	NO	YES	PQ118
116. Before you were 15, did you sometimes steal or shoplift things or forge someone's signature?	NO	YES	PQ119
117. Before you were 15, did you run away from home and stay away overnight?	NO	YES	PQ120
118. Before you were 13, did you often stay out very late, long after the time you were supposed to be home?	NO	YES	PQ121
119. Before you were 13, did you often skip school?	NO	YES	PQ122