THE WASHTON GROUP

NEW PATIENT QUESTIONNAIRE

The information you provide is strictly confidential and will not be released without your written consent

Today's date _____ /_____/_____

PLEASE WRITE CLEARLY

Name: (Last) _____ First:_____

How did you find out about us?

[ ] internet search (if possible, please tell us what search items led you to our website)
[ ] Professional referral (please specify) : [ ] Former patient [ ] Friend/relative [ ] Dr. Washton's books [ ] Other (please specify

What types of problem(s) are you seeking help for (check all that apply): [ ] Alcohol abuse [ ] Other drug abuse [ ] Depression
[ ] Anxiety [ ] Bipolar Disorder [ ] ADHD [ ] PTSD [ ] Relationship problems [ ] Other (specify):

Your Mailing Address: _____City/Town:_____State:_____ ZIP:_____

Mobile Phone: ( ) _____ Other Phone: ( ) _____

E-mail: _____

Date of birth: _____/_____/_____ Current Age:_____ Place of birth:_____ Where did you grow up?_____

Gender: [ ] Male [ ] Female *Race*: [ ] Caucasian [ ] African American [ ] Hispanic [ ] Asian [ ] Other:
Marital status: [ ] Single, Never Married [ ] Married [ ] Separated [ ] Divorced [ ] Widowed
Current living situation: [ ] alone [ ] with spouse/mate [ ] with parents [ ] with siblings [ ] other:

EMERGENCY CONTACT Name:_____ Relationship to you:_____

Mobile phone: ( ) _____ Other phone: ( ) _____

Your Primary Care Physician:_____ Office number: ( ) _____

YOUR CURRENT OCCUPATION: _____ POSITION:_____

Employer:_____ How long at this job?_____

YOUR EDUCATION & TRAINING

School or Facility	Dates Attended	Degree	Major Area of Study

For Healthcare Professionals: Licensure/degree: [ ] MD [ ] DO [ ] DC [ ] DDS/DMD [ ] Ph.D/PsyD [ ] RPh. [ ] Pharm.D. [ ] RN [ ] RPA [ ] Other:

- What is your specialty area of practice? _____Years practicing_____
- Professional School Attended: _____ Year Graduated:_____
- Residency Program:_____ Specialty_____ Year completed:_____
- Fellowship Program: _____ Subspecialty_____Year completed:_____
- Describe any current or pending legal/regulatory problems regarding your license to practice.

YOUR HISTORY OF SUBSTANCE USE

SUBSTANCE	Time Since Last Use	Currently a "Problem"? (✓)	Ever a "Problem"? (✓)	Longest time able to drug when you were deliberately trying to stop using it
Alcohol				
Prescription Opioids (specify) Vicodin, Percoset, OxyContin, Fentanyl				
Prescription Tranquilizers (specify) Ativan, Xanax. Klonopin, Valium				
Prescription Sleeping Pills (specify) Ambien, Sonata, etc				
Prescription Stimulants (specify) Adderrall, Vyvanse, Ritalin, etc				
Cocaine snorting (powder)				
Cocaine smoking (crack)				
Methamphetamine				
Heroin				
Methadone				
Marijuana				
Hallucinogens (specify)				
"Ecstacy" (MDMA)				
"Special K" (ketamine)				
GHB "G"				
Nitrous Oxide /"Whippets"				
Other (specify):				

YOUR ALCOHOL & DRUG USE DURING THE <u>PAST FIVE DAYS</u>

	SUBSTANCES USED	AMOUNTS USED
Today		
Yesterday		
2 days ago		
3 days ago		
4 days ago		

Which substance do you consider to be your <u>primary</u> substance of choice:
(i.e., the one that causes you the most problems and/or has been the most difficult for you to manage)

[ ] Alcohol [ ] Cocaine [ ] Marijuana [ ] Heroin [ ] Methamphetamine [ ] Ecstasy [ ] Nitrous Oxide
[ ] Prescription Opioids (specify) [ ] Prescription Stimulants (specify) [ ] Prescription Tranquilizers (specify) [ ] Other (specify)

Alcohol Use

When you drink alcohol, what types of beverages do you most often drink? (check all that apply)
[ ] beer [ ] wine [ ] vodka [ ] gin [ ] scotch/whiskey [ ] other (specify)_____

How many drinks do you usually have ? per day _____ per week _____

Do you experience any physical problems when you try to stop drinking? [ ] No [ ] Yes, check all that apply
[ ] shakes or trembling [ ] sweating [ ] vomiting [ ] sleep problems [ ] seizures [ ] hallucinations

Have you ever experienced physical withdrawal or other medical complications in any prior attempts to stop drinking?
[ ] No [ ] Yes, please describe

Do you consider your current drinking pattern to be a problem? [ ] Yes [ ] No

If yes, how would you like to change it? [ ] reduce amount [ ] reduce frequency [ ] stop completely [ ] other (specify)

If you stopped drinking for periods of time in the past, what was the longest time you remained abstinent from alcohol? _____

Think of the ONE occasion during the past month or so when you consumed the MOST drinks.

How many drinks did you have? _____ Over what period of time? _____

How intoxicated were you when you finished drinking? [ ] mildly [ ] moderately [ ] severely

Did you say or do anything while intoxicated that got you into trouble or that you now regret? [ ] No [ ] Yes: describe

The next day, did you have trouble remembering what you said or did? [ ] No [ ] Yes

Alcohol and Drug Use

- Have you ever found yourself thinking a great deal about alcohol/drugs or being preoccupied with using? [ ] Yes [ ] No
- Have you ever experienced cravings or a strong compulsion to use alcohol/drugs? [ ] Yes [ ] No
- Have you ever had difficulty in reducing or totally stopping your alcohol/drug use? [ ] Yes [ ] No
- Have you ever used more frequently and/or in larger amounts than you intended to? [ ] Yes [ ] No
- Have you ever been under this influence of alcohol/drugs while driving a car or operating dangerous machinery? [ ] Yes [ ] No
- Has your use ever caused you to miss workdays or impaired your productivity or judgment at work? [ ] Yes [ ] No
- Have you ever become less sociable, socially withdrawn, or isolated as a result of using alcohol/drugs? [ ] Yes [ ] No
- Have you ever given up recreational activities/exercise, or other healthy pursuits due to alcohol/drug use? [ ] Yes [ ] No
- Has your self-esteem or self-image ever been negatively affected by your alcohol/drug use? [ ] Yes [ ] No
- Have relationships with a mate, family members or significant others been damaged by your alcohol/drug use? [ ] Yes [ ] No
- Have you ever used alcohol/drugs to "medicate" yourself for depression, anxiety, or other negative moods? [ ] Yes [ ] No
- Has your substance use been associated "STD risky" sexual behavior such as having sexual encounters with unknown partners or having STD-risky unprotected sex with someone other than your primary mate? [ ] Yes [ ] No
- Do you feel that you have an alcohol/drug problem serious enough to warrant treatment? [ ] Yes [ ] No

YOUR TOTAL NUMBER OF "YES" RESPONSES _____

ALCOHOL USE QUESTIONNAIRE

Instructions: Please read each question carefully and answer all the questions even if they do not apply to you. Compute your score at the end by adding up the numbers associated with each of your answers.

1. How often do you have a drink containing alcohol?
(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily (4) 4 or more times a week

2. How many drinks containing alcohol do you have on a typical day when you are drinking?
(0) 1 or 2 (1) 3 or 4 (2) 5 or 6 (3) 7, 8, or 9 (4) 10 or more

3. How often do you have six or more drinks on one occasion?
(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

4. How often during the last year have you found that you were not able to stop drinking once you had started?
(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

5. How often during the last year have you failed to do what was normally expected from you because of drinking?
(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

6. How often during the last year have you been unable to remember what happened the night before because you had been drinking?
(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

7. How often during the last year have you needed an alcoholic drink first thing in the morning to get yourself going after a night of heavy drinking?
(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

8. How often during the last year have you had a feeling of guilt or remorse after drinking?
(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily

9. Have you or someone else been injured as a result of your drinking?
(0) No (2) Yes, but not in the last year (4) Yes, during the last year

10. Has a relative, friend, doctor, or another health professional expressed concern about your drinking or suggested you cut down?
(0) No (2) Yes, but not in the last year (4) Yes, during the last year

YOUR TOTAL SCORE: _____

SPECIFIC PROBLEMS RELATED TO YOUR ALCOHOL/DRUG USE

PSYCHOLOGICAL
[ ] Irritability, short temper [ ] Self-hate [ ] Depression [ ] Suicidal thoughts or actions [ ] Homicidal thoughts or actions
[ ] Paranoia, suspiciousness [ ] Memory [ ] Anxiety or panic attacks [ ] Other (describe):

SEXUAL
[ ] Loss of sexual desire [ ] Sexual obsession [ ] Sex with strangers [ ] AIDS-risky sex [ ] Inability to achieve orgasm
[ ] Inability to achieve or sustain erection [ ] Other (describe):

RELATIONSHIPS
[ ] Arguments with mate [ ] Violence with mate [ ] Breakup of marriage or relationship [ ] Loss of friends
[ ] Arguments with parents or siblings [ ] Other (describe):

JOB OR FINANCIAL
[ ] Job loss or threatened job loss [ ] Lateness or absenteeism [ ] Less productive at work [ ] In debt
[ ] Falling behind in paying bills [ ] Other (describe):

LEGAL
[ ] Arrested for possession or sale of illegal drugs [ ] Arrested for DWI [ ] Other:

OTHER CONSEQUENCES: please describe

TREATMENT HISTORY

INPATIENT DETOX, REHAB or PSYCHIATRIC HOSPITAL

Facility Name	Reason for Admission	Admission Date mo/yr	Length of Stay	Results- completed/dropped out

OUTPATIENT TREATMENT PROGRAM

Facility Name	Reason for Admission	Admission Date mo/yr	Length of Stay	Results- completed/dropped out

INDIVIDUAL THERAPY: Are you currently seeing a psychologist, psychiatrist, or other therapist? [ ] No [ ] Yes

Practitioner's Name: _____

Primary reason for seeking help_____

Seeing this clinician for how long? _____ How useful has it been for you?_____

What are the most important issues that have been addressed in your therapy?

PRESCRIBED MEDICATIONS YOU ARE CURRENTLY TAKING

Medication	Dose per day	Condition or Illness	Doctor's Name	Approx starting date	Take as prescribed?

YOUR SELF-HELP INVOLVEMENT

- Have you ever attended a 12-step meeting of AA/CA/NA? [ ] No [ ] Yes- For how long? _____
- How often do you go to meetings now? _____ Do you have a sponsor? [ ] Yes [ ] No
- Do you maintain regular contact with your sponsor? [ ] Yes [ ] No If Yes, how often? _____
- Are you doing step work with your sponsor? [ ] Yes [ ] No
- How important to your recovery is your current involvement in the 12-step program?
  [ ] None [ ] Minimal [ ] Moderate [ ] Very Important [ ] Extremely Important

Please Answer ALL Questions Below

- Have you ever been hospitalized or treated in an ER for alcohol/drug overdose? [ ] No [ ] Yes [ ] Past 30 days?
- Have you ever had seizures, convulsions, or epilepsy? [ ] No [ ] Yes [ ] Past 30 days?
- Have you ever had blackouts (memory gaps) due to alcohol/drug use? [ ] No [ ] Yes [ ] Past 30 days?
- Have you ever felt suicidal or had repeated thoughts about harming yourself? [ ] No [ ] Yes [ ] Past 30 days?
- Have you ever planned out or chosen a specific method for killing yourself? [ ] No [ ] Yes [ ] Past 30 days?
- Have you ever attempted to kill or seriously harm yourself? [ ] No [ ] Yes [ ] Past 30 days?
- Have you ever been hospitalized due to a suicide attempt or suicidal thoughts? [ ] No [ ] Yes [ ] Past 30 days?
- Are you afraid that you might try to harm yourself in the near future? [ ] No [ ] Yes [ ] Past 30 days?
- Do you have a history of being violent toward other people? [ ] No [ ] Yes [ ] Past 30 days?
- Do you ever have persistent thoughts or fantasies about harming other people? [ ] No [ ] Yes [ ] Past 30 days?

Please explain any "YES" answers:

Mood and Mental State: OVER THE PAST 30-60 DAYS:

- Have you been feeling depressed, down, blue, or hopeless on a regular basis? [ ] No [ ] Yes
- Has your appetite significantly increased or decreased? [ ] No [ ] Yes
- Have you lost or gained a significant amount of weight? [ ] No [ ] Yes
- Have you experienced problems falling asleep or staying asleep on most nights? [ ] No [ ] Yes
- Have you been sleeping too much or having trouble getting out of bed?[[ ] No [ ] Yes
- Have you been feeling worthless and/or overwhelmed with guilt? [ ] No [ ] Yes
- Have you been feeling irritable, agitated, restless, or unable to concentrate? [ ] No [ ] Yes
- Have you lost interest or reduced participation in pleasurable activities? [ ] No [ ] Yes
- Have you been less interested in sex? [ ] No [ ] Yes
- Have you been avoiding social contact or become withdrawn and isolated? [ ] No [ ] Yes
- Have you been feeling overwhelmed with sadness or had crying spells? [ ] No [ ] Yes

- Has your overall energy level decreased or been much lower than usual? [ ] No [ ] Yes
- Have you been feeling that life may not be worth living? [ ] No [ ] Yes
- In the last month, has there been a period of time when you were feeling so good, high, excited or hyper that other people thought you were not your normal self or you got into trouble? (Did anyone say you were manic?) ..... [ ] No [ ] Yes
- Other than when you were depressed or feeling high, has there been a time when you heard voices, had visions, or saw or smelled things that others couldn't see or smell? ..... [ ] No [ ] Yes
- Have you ever had a panic attack, when you felt frightened, anxious, uncomfortable, worried about going crazy or suddenly developed a lot of physical symptoms (e.g., heart-pounding, trembling, dizziness)? ..... [ ] No [ ] Yes
- Was there ever anything that you had to do over and over again and couldn't resist doing, like washing your hands again and again, counting up to a certain number or checking something several times to make sure you'd done it right? ..... [ ] No [ ] Yes
- Have you been afraid of leaving the house alone, being in crowds, standing in line, or traveling on buses or trains? ..... [ ] No [ ] Yes

YOUR CHILDREN (if any)

Name	Age	School Grade Occupation	Resides with you?	History of Behavior Problems?	History of Alcohol/Drug Problems?

YOUR FAMILY-OF-ORIGIN

	Name	Age	Occupation	History of Alcohol/Drug Abuse?	History of Mental Illness ?	If deceased- Year/Cause/Age
Father						
Mother						
Brother/Sister						
Brother/Sister						
Brother/Sister						
Brother/Sister						
Brother/Sister						
Brother/Sister						
Brother/Sister						
STEP-MOTHER						
STEP-FATHER						

LEARNING AND BEHAVIOR PROBLEMS

- Did you ever have any learning, attention, hyperactivity, or other behavior problems in school? [ ] No [ ] Yes- describe
- Were you ever diagnosed as having: [ ] learning disability [ ] attention deficit disorder [ ] hyperactivity disorder
- Do you have difficulty with distractibility, short attention span, impulsivity, or restlessness? [ ] No [ ] Yes- describe
- Did you ever receive tutoring, therapy, or medication for these problems? [ ] No [ ] Yes, describe

TRAUMATIC/ADVERSE LIFE EXPERIENCES

Did you experience any of the following during childhood:

- Recurrent and severe physical abuse [ ] No [ ] Yes
- Recurrent and severe emotional abuse [ ] No [ ] Yes
- Sexual abuse [ ] No [ ] Yes
- Growing up in a household with:
  - An alcohol or drug abuser [ ] No [ ] Yes
  - A member being imprisoned [ ] No [ ] Yes
  - A mentally ill, chronically depressed, or institutionalized member [ ] No [ ] Yes
  - Witnessed your mother being physically abused or intimidated [ ] No [ ] Yes
  - Both biological parents not being present [ ] No [ ] Yes

Have you ever experienced any of the following traumatic life events:

- physical or sexual abuse [ ] No [ ] Yes
- life threatening illness, injury or catastrophic situation [ ] No [ ] Yes
- unexpected death of loved one or caregiver [ ] No [ ] Yes
- survived a natural disaster or near death experience [ ] No [ ] Yes

If Yes to any of the above, please describe below and answer the following questions:

- Do you re-experience the negative or traumatic event in at least one of the following ways?
  [ ] No [ ] Yes Repeated, distressing memories and/or dreams?
  [ ] No [ ] Yes Acting or feeling as if the event were happening again (flashbacks or a sense of reliving it)?
  [ ] No [ ] Yes Intense physical and/or emotional distress when you are exposed to things that remind you of the event
- Do you avoid reminders of the event and feel numb, compared to the way you felt before, in three or more of the following ways?
  [ ] No [ ] Yes Avoiding thoughts, feelings, or conversations about it?
  [ ] No [ ] Yes Avoiding activities, places, or people who remind you of it?
  [ ] No [ ] Yes Blanking on important parts of it?
  [ ] No [ ] Yes Losing interest in significant activities of your life?
  [ ] No [ ] Yes Feeling detached from other people?
  [ ] No [ ] Yes Feeling your range of emotions is restricted?
- Are you troubled by any of the following that may be related to previous traumatic events:
  [ ] No [ ] Yes Problems sleeping?
  [ ] No [ ] Yes Irritability or outbursts of anger?
  [ ] No [ ] Yes Problems concentrating?
  [ ] No [ ] Yes Feeling "on guard"?
  [ ] No [ ] Yes An exaggerated startle response?

GAMBLING BEHAVIOR

- Has gambling ever been a problem for you? [ ] No [ ] Yes
- Do you lose time from work/school due to gambling? [ ] No [ ] Yes
- Has gambling ever made your home life unhappy? [ ] No [ ] Yes
- Have you ever felt remorse after gambling? [ ] No [ ] Yes
- Do you ever gamble to get money to pay debts or to otherwise solve other financial difficulties? [ ] No [ ] Yes
- After losing, do you feel you must return as soon as possible and win back your losses? [ ] No [ ] Yes
- After a win, do you have a strong urge to return and win more? [ ] No [ ] Yes
- Do you ever have to borrow to finance your gambling? [ ] No [ ] Yes
- Are you away from home or unavailable to the family for long periods of time when you gamble? [ ] No [ ] Yes
- Do you promise faithfully that you will stop gambling and beg for another change, yet continue to gamble? [ ] No [ ] Yes

EATING PROBLEMS

- Have you ever suspected or been told that you have an eating problem? [ ] No [ ] Yes
  If Yes, [ ] bulimia? [ ] anorexia [ ] compulsive overeating

- Do you go on food binges where you eat several meals worth of calories in one sitting? [ ] No [ ] YeS
- Do you ever force yourself to vomit after an eating binge or take laxative or diuretics? [ ] No [ ] Yes
- Are you obsessed with your body proportions to the point where it dictates too much of your mental life? [ ] No [ ] Yes
- Would you label yourself a "compulsive eater", one who engages in episodes of uncontrolled eating? [ ] No [ ] Yes
- Are you preoccupied with the desire to be thinner? [ ] No [ ] Yes
- Are you chronically dissatisfied with your body weight or shape? [ ] No [ ] Yes
- Do you binge and/or starve yourself in response to stress? [ ] No [ ] Yes
- Do other people seem worried about your eating patterns and say that you have a problem with food? [ ] No [ ] Yes
- Have your unusual eating patterns caused you any medical problems? [ ] No [ ] Yes
- Have you ever attended a self-help group or weight-loss program? [ ] No [ ] Yes
- Have you ever used cocaine, amphetamines, diet pills, or other drugs to control your appetite? [ ] No [ ] Yes

LINKAGE between SUBSTANCE USE and SEX

- Has your alcohol or drug use ever been associated with sex? [ ] Yes (answer all questions below) [ ] No (skip this section)
- Which of the substances that you have used are most strongly linked with sex? [ ] cocaine [ ] methamphetamine [ ] alcohol [ ] other-
- When using substances do you get involved in (check all that apply): [ ] compulsive masturbation [ ] sex with prostitutes/escorts [ ] strip clubs [ ] porno movies [ ] telephone sex [ ] internet pornography [ ] sadomasochistic sex [ ] asphyxiation [ ] sex with transvestites [ ] Other: *specify* –
- Approximately how often does your substance use involve sexual thoughts, feelings, fantasies, or behaviors? [ ] always [ ] almost always [ ] most of the time [ ] sometimes [ ] almost never [ ] never

- Does your substance use stimulate your sex drive and fantasies? [ ] No [ ] Yes
- Does your substance use impair your sexual performance (e.g., prevent orgasm and/or erection) ? [ ] No [ ] Yes
- Are you more likely to have sex (intercourse, oral sex, masturbation, etc..) when using substances? [ ] No [ ] Yes
- Are you more likely to have sex with a prostitute, pickup, other unknown partner, or someone besides your spouse or primary mate when using substances? [ ] No [ ] Yes
- Has your use of substances increased your preoccupation and obsession with sex or made your sex drive abnormally high? [ ] No [ ] Yes
- In prior attempts to stop using substances, have sexual thoughts, feelings, and/or fantasies perpetuated your drug use and contributed to relapse? [ ] No [ ] Yes
- Are you concerned that if you stop using this substance sex will not be as interesting or pleasurable for you? [ ] No [ ] Yes
- Have sexual fantasies or desires ever increased your chances of using substances? [ ] No [ ] Yes
- If you try to stop using substances are you concerned that your sexual fantasies or desires will make it harder for you to stop ? [ ] No [ ] Yes
- If you are heterosexual, have you experienced homosexual fantasies or engaged in sex with men while under the influence of substances? [ ] No [ ] Yes
- Are you less likely to practice safe sex under the influence of substances (e.g., not use condoms, be less careful about who you choose as a sex partner, etc.) ? [ ] No [ ] Yes
- Prior to getting involved with substances were you ever have concerned that your sex drive was abnormally high or that you were preoccupied or obsessed with sex? [ ] No [ ] Yes
- Prior to getting involved with substances were you ever concerned that your sex drive was abnormally low or that your sexual performance was inadequate? [ ] No [ ] Yes
- Do you feel that your treatment should address substance-related sexual issues? [ ] No [ ] Yes

MEDICAL

- Any current medical problems? [ ] No [ ] Yes, describe-
- Currently under a doctor's care for these problems? [ ] No [ ] Yes, name of doctor:
- Any serious illness within the past year? [ ] No [ ] Yes, describe-

- Have you EVER had? (check all that apply): [ ] high blood pressure [ ] heart disease [ ] epilepsy, seizures, convulsions [ ] kidney disease [ ] diabetes [ ] colitis [ ] thyroid disease [ ] pancreatitis [ ] cancer [ ] TB [ ] HIV [ ] Hep A [ ] Hep B [ ] Hep C [ ] serious head/brain injury [ ] other serious illnesses or major surgeries (describe):

FINANCIAL

- Are you currently experiencing financial problems? [ ] No [ ] Yes
- Are you falling behind in paying: [ ] rent [ ] credit card [ ] mortgage/loans [ ] car lease
- Are you having to borrow money to keep up with monthly living expenses? [ ] No [ ] Yes

LEGAL

- Have you ever been charged with a DUI or DWI ? [ ] No [ ] Yes, please specify year and disposition
- Have you ever been arrested or convicted of drug possession or dealing? [ ] No [ ] Yes, please specify year and disposition
- Have you ever been arrested or convicted of any other crime? [ ] No [ ] Yes, please specify year and disposition
- Are there any legal charges or lawsuits pending against you? [ ] No[ ] Yes, please specify

RELATIONSHIPS

- Your sexual orientation: [ ] heterosexual [ ] homosexual [ ] bisexual
- Are you currently involved in a significant relationship? [ ] Yes [ ] No
- How many times have you been married? _____
- If currently married, for how long? _____ Reasons for prior separation/divorce:

- Name of your current spouse/mate:
- Spouse/mate's Age: _____ Occupation:
- Current areas of conflict with your mate:
- Does he/she have any history of emotional or psychiatric problems? [ ] No [ ] Yes, please explain:
- Does he/she have a history of alcohol or drug problems? [ ] No [ ] Yes, please explain:

What are your treatment goals and what are the major obstacles to achieving those goals?

Alcohol/Drug Use:

Mood/Mental State:

Relationship(s):

Other Issues: