

PSYCHOLOGICAL PROFILE

Central Office

International March of The Living

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New York, NY 10036

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Name of Applicant: Email.....

Home Address:

Name of Interviewer.....

This is to be completed by the interviewer and then forwarded with the **Application Form, Medical Form and Deposit of \$400** to your Local Agency or Federation.

- | | YES | NO | | YES | NO |
|---|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 1. Have you had any counseling or psychotherapy? | <input type="checkbox"/> | <input type="checkbox"/> | 10. Do you have feelings of helplessness or hopelessness? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have a lot of friends? | <input type="checkbox"/> | <input type="checkbox"/> | 11. Do you have eating problems such as: | | |
| 3. Do you prefer to be by yourself, or are you often lonely? | <input type="checkbox"/> | <input type="checkbox"/> | eating too much | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have difficulty staying seated for long periods of time? | <input type="checkbox"/> | <input type="checkbox"/> | eating too little | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever had thoughts of harming yourself? | <input type="checkbox"/> | <input type="checkbox"/> | gorge and vomit | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever taken tranquilizers, antidepressants or psychotropic medication? | <input type="checkbox"/> | <input type="checkbox"/> | laxative use | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you have attacks of anxiety or panic, claustrophobia or other phobias? | <input type="checkbox"/> | <input type="checkbox"/> | 12. Do you use alcohol? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you have periods of blackouts or forgetting? | <input type="checkbox"/> | <input type="checkbox"/> | 13. Do you use drugs? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you have explosive temper outbursts? | <input type="checkbox"/> | <input type="checkbox"/> | 14. Do you have sleep problems such as: | | |
| | | | sleep too much or too little | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | trouble falling asleep | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | trouble staying asleep | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | recurrent nightmares | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | 15. Have you ever experienced: | | |
| | | | a loss | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | an emotional trauma | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | a suicide of a relative or friend | <input type="checkbox"/> | <input type="checkbox"/> |

Comments:

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