EXHIBIT 1

PLAINTIFF PROFILE FORM
***In re Abilify (Aripiprazole) Products Liab. Litig.*, MDL 2734 (N.D. Fla.)**
ATTORNEY:_____
LAW FIRM: _____

I. PLAINTIFF'S INFORMATION

Full Name of Plaintiff: _____

Address: _____

DOB: _____ **Social Security No.**: _____ **Married?:** ☐ Yes ☐ No

If married, spouse's name: _____

Children? ☐ Yes ☐ No **Ages of Children**: ☐ 0-17 ☐ 18-25 ☐ >25

Occupation: _____

II. MEDICAL INFORMATION

A. Abilify® Start Date:_____ **Abilify® End Date:** _____

B. Between these dates, did you ever stop Abilify for more than 2 months: ☐ Yes ☐ No

C. Abilify® Daily Dosage: _____

D. Diagnosis Leading to Abilify® Prescription: (Check all that apply)

☐ Schizophrenia
☐ Bipolar Disorder
☐ Major Depressive Disorder/Depression
☐ Tourette's Disorder
☐ Autism and/or Autism related disorders
☐ Agitation/Irritability
☐ Anxiety
☐ Social phobia
☐ Attention deficit disorder (ADD) and/or attention deficit hyperactivity disorder (ADHD)
☐ Dementia
☐ Psychosis
☐ Eating disorder
☐ Insomnia
☐ Obsessive compulsive disorder
☐ Augmentation with SSRI
☐ Personality disorder
☐ Post-traumatic stress disorder (PTSD)
☐ Substance abuse
☐ Alcohol abuse
☐ Other—Specify: _____

E. Name and Address of Prescribing Physician(s):

1. Provider Name: _____
   Provider Address: _____
2. Provider Name: _____
   Provider Address: _____

ATTACH ADDITIONAL SHEETS AS NECESSARY

F. Were you given any written or oral instructions, directions or warnings regarding Abilify at any time during which you were using the drug? ☐ Yes ☐ No

G. Have you ever been diagnosed with a compulsive disorder (e.g., obsessive compulsive disorder, etc.), addiction disorder, or impulse control disorder? ☐ Yes ☐ No
If *YES*, please provide the following information:

1. Diagnosis: _____

   Provider Name: _____

   Provider Address: _____

   Date: _____

H. Please provide a list of all treating physicians or healthcare providers who have provided psychiatric/psychological care or counseling services to you from the five years before you started Abilify® to present the dates of such services:

1. Provider Name: _____

   Provider Address: _____

   Dates: _____

2. Provider Name: _____

   Provider Address: _____

   Dates:_____

ATTACH ADDITIONAL SHEETS AS NECESSARY

I. Have you ever received any hospitalizations, institutionalizations, or in-patient treatment related to your mental health? ☐ Yes ☐ No

J. Substance Use History – Please check all that apply:

☐ I have never consumed alcohol.
☐ I have consumed alcohol.
☐ At some point in my life, I have consumed more than 10 drinks in a week within 5 years of taking Abilify.
☐ I have used an illegal drug or substance (e.g., cocaine, heroin, etc.) within 5 years of taking Abilify.
☐ I have used a prescription drug without having a prescription for that drug within 5 years of taking Abilify
☐ I have been diagnosed with an addiction to alcohol, prescription or illegal drugs

K. Have you ever been diagnosed with Parkinson's Disease (PD) or Restless Legs Syndrome (RLS)? ☐ Yes ☐ No

III. COMPULSIVE BEHAVIORS AND DAMAGES

A. Prior to taking Abilify were you diagnosed with any of the following::

- ☐ Compulsive Gambling
- ☐ Compulsive Spending and/or Shopping
- ☐ Compulsive Sexual behavior
- ☐ Compulsive Pornography
- ☐ Compulsive Playing video games
- ☐ Compulsive Eating
- ☐ Compulsive Hoarding
- ☐ Compulsive Trichotillomania or skin picking
- ☐ Compulsive Checking, counting, washing, repeating
- ☐ Compulsive Theft/Shoplifting
- ☐ Attempted Suicide / Suicidal Thoughts
- ☐ Other—Specify: _____

B. Please check *all* obsessive/compulsive/impulsive behaviors you claim were caused as a result of Abilify®.

- ☐ Gambling
- ☐ Spending and/or Shopping
- ☐ Sexual behavior
- ☐ Pornography
- ☐ Playing video games
- ☐ Compulsive Eating
- ☐ Hoarding
- ☐ Trichotillomania and skin picking
- ☐ Checking, counting, washing, and repeating
- ☐ Theft/Shoplifting
- ☐ Attempted Suicide / Suicidal Thoughts
- ☐ Other—Specify: _____

C. Temporal Relationship

1. When did you first begin experiencing impulsive or compulsive behaviors after you started taking Abilify?

   ☐ Less than 1 month after ☐ Within 1 to 3 months after ☐ Within 4 to 6 months after ☐ Within 7 to 12 months after ☐ More than 1 year after

2. When did you stop experiencing all impulsive or compulsive behaviors after you stopped taking Abilify?

   ☐ Less than 1 month after ☐ Within 1 to 3 months after ☐ Within 4 to 6 months after ☐ Within 7 to 12 months after ☐ Never

3. If you restarted Abilify after stopping it, do you claim that you experienced similar signs and symptoms of impulsive or compulsive behaviors when you restarted Abilify (i.e., rechallenge)? ☐ Yes ☐ No

D. Please check *all* damages you allege were a result of your Abilify® usage.

- ☐ Gambling Losses
- ☐ Shopping or Spending Expenses
- ☐ Bankruptcy
- ☐ Divorce
- ☐ Job Loss
- ☐ Home Foreclosure or Eviction
- ☐ Vehicle Repossession
- ☐ Contraction of a STD
- ☐ Unplanned Pregnancy
- ☐ Weight Loss Surgery
- ☐ In-Patient Psychiatric Hospitalization
- ☐ Other—Specify: _____

E. Gambling and/or other spending losses: $_____ Estimated Economic losses (non- gambling losses) calculated to date: $_____

Plaintiff reserves the right to supplement any and all response upon receipt of additional information.

CERTIFICATION

In an effort to be forthcoming and to provide non-privileged information, the information provided in this profile form is, by necessity, not based solely upon my knowledge and includes non-privileged information assembled and collected by my attorneys which may not be known to the executing party.

I declare that all of the information provided in this Plaintiff Profile Form is true and correct to the best of my knowledge.

_____	_____	_____
Signature	Print Name	Date

If you are completing this form in a representative capacity, please list your name, address, and relationship to the Plaintiff:

_____

_____

_____