NEW PATIENT QUESTIONNAIRE

Date _____

Name _____ Date of Birth _____

Who were you referred by? _____

Marital status: __married __single ___divorced __widowed __long term relationship

Do you have any children? __yes __no If yes, how many____ ages of children_____

Current living situation: ___ apartment/house ___ community residence

___ supported housing ___ shelter___ other: _____

How long have you lived at current residence? _____ Do you live alone? __ yes __ no

If no, who lives with you?

Name(s)	Relationship
_____	_____
_____	_____
_____	_____
_____	_____

FINANCES

What are your present sources of financial support? (Check all that apply)

__ Employment __ Savings __ Disability __ Worker's comp

__ Spouse __ Parents __ Retirement __ Investments __Other _____

CURRENT PROBLEMS

Please check **all that currently apply**. (past month)

[ ] Depressed mood

[ ] Decreased motivation or pleasure

[ ] Crying

[ ] Guilty feelings

[ ] Hopelessness

[ ] Suicidal thoughts

[ ] Recurrent thoughts of death

[ ] Change in sexual interest or drive

[ ] Impaired sexual performance

[ ] Eating disturbances

[ ] Sleep disturbance

[ ] Irritability

[ ] Anger

[ ] Aggression

[ ] Violent fantasies

[ ] Fear of losing control

[ ] Anxiety

[ ] Panic attacks

[ ] Embarrassed easily; very shy

[ ] Excessive worrying

[ ] Phobias

[ ] Intrusive daytime thoughts or flashbacks

[ ] Frequent nightmares

[ ] Feeling disconnected from self

[ ] Extreme happiness/energy

[ ] Extreme mood swings

[ ] Racing thoughts

[ ] Seeing or hearing things that are not real

[ ] Feel like people are trying to hurt you

[ ] Poor concentration

[ ] Problems with memory

[ ] Recent stressful life events

Comments: _____

PSYCHIATRIC HISTORY

Have you ever met with a mental health professional (psychiatrist/psychologist/therapist)? [ ] yes[ ] no

If so, please provide the following information:

Name and degree	City	Problem	Dates
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever been sexually, emotionally or physically abused by a family member or anyone else?

[ ] yes [ ] no

Have you ever been hospitalized for a psychiatric problem? [ ] yes[ ] no

If so, please provide the following information for each hospitalization.

Name of Hospital	City	Year
_____	_____	_____
_____	_____	_____

In the past month:

Have you wished you were dead or wished you could go to sleep and not wake up? **[ ] yes[ ] no**

Have you actually had any thoughts of killing yourself? **[ ] yes[ ] no**

Have you been thinking about or planning how you might kill yourself? **[ ] yes[ ] no**

Have you had intention of acting on your thoughts or carrying out your plan? **[ ] yes [ ] no**

In the past (at any time):

Have you ever attempted to kill yourself? **[ ] yes[ ] no**

If yes, how many times and how long ago? _____

In the past month:

Have you ever purposely hurt yourself? (cutting, burning, etc.) **[ ] yes [ ] no**

In the past (at any time):

Have you ever had thoughts or fantasies about harming other people? **[ ] yes [ ] no**

Have you ever been violent toward other people? **[ ] yes[ ] no**

Do you currently have access to a gun? **[ ] yes [ ] no**

MEDICATIONS

List all prescribed **(psychiatric AND medical**) AND over the counter medications that you take regularly. Include vitamins, supplements, etc.

Medication Name	Dose	Tablets per Day	Date Started	Prescribed By
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Please list all psychiatric medications that either has **not been helpful** or that you **stopped taking**.

Medication	Max Dose	Length Taken	Last taken	Reason Stopped
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Are you allergic to any medications? **[ ] yes [ ] no**

If so, please provide medication name and describe the reaction that you had.

_____

Have you ever had any other serious reactions to any specific medication? **[ ] yes [ ] no**

If so, please provide medication name and the reaction that you had.

_____

SUBSTANCE USE

Caffeine [ ] none [ ] cups of coffee per day _____ [ ] cans of soda a day _____

Cigarettes [ ] none [ ] packs per day _____

Would you like to quit smoking? **[ ] yes [ ] no**

Alcohol Use – In the last year…

(One standard drink= a regular size can of beer (12oz); a small glass of wine (5oz); one "shot" (1.5oz) of liquor)

Please circle the correct answer:

1. In the last year, how often do you have a drink containing alcohol?
   (0) Never **(Skip Questions 2-10)**
   (1) Monthly or less
   (2) 2 to 4 times a month
   (3) 2 to 4 times a week
   (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 this 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
   (1) Yes, but not in the last year
   (2) 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
    (1) Yes, but not in the last year
    (2) Yes, during the last year

If you drink alcohol:

1. Have you ever felt you needed to cut down on your drinking? **[ ] yes [ ]no**
2. Have people annoyed you by criticizing your drinking? **[ ] yes [ ]no**
3. Have you ever felt guilty about drinking? **[ ] yes [ ]no**
4. Have you ever felt you needed a drink first thing in the morning (eye-opener) to steady your nerves or to get rid of a hangover? **[ ] yes [ ]no**

Have you ever participated in a 12-step program (AA, NA, Gamblers, etc) [ ] yes[ ] no
Have you ever been treated in an outpatient drug-related program? [ ] yes[ ] no

Where? _____ When? _____

Have you ever been treated in an inpatient drug-alcohol rehab? [ ] yes[ ] no

Where? _____ When? _____

SUBSTANCE USE

Name of the drug (Please include prescription opiates and tranquilizers (Valium, Xanax, Halcion, Ativan, Librium etc)	Age first used	When last used	How often do you use?
Comments:			

***If you are taking any medication from benzodiazepine family or tranquilizers (Valium, Ativan, Klonopin, Xanax, Librium, Halcion etc), are you willing to have them tapered off over time? **[ ] yes [ ] no**

FAMILY HISTORY

Is there any **family history** of any of the following psychiatric problems? **Please write the relationship of the family member next to the problem**

[ ] Depression _____

[ ] Suicide or suicide attempts _____

[ ] Schizophrenia _____

[ ] Autism _____

[ ] Substance abuse _____

[ ] Hospitalization for mental illness _____

[ ] Outpatient treatment for mental illness _____

[ ] Mania _____

[ ] Anxiety or panic disorder _____

[ ] Paranoia _____

[ ] Eating disorder _____

[ ] Obsessive compulsive disorder _____

[ ] Other _____

Is your Father __alive __deceased __unknown? If deceased, what did he pass from? _____ At what age?____
Is your Mother __alive __deceased __unknown? If deceased, what did she pass from? _____ At what age?____

MEDICAL HISTORY

Physician/Program Name Address Telephone Number

_____ _____ _____

_____ _____ _____

_____ _____ _____

Date of last Physical Exam _____ Weight _____ Height _____

Have you ever been hospitalized for a medical (physical) reason? **[ ] yes [ ] no**

Date of Hospitalization _____

What was the reason for your hospitalization? _____

Have you ever had surgery? **[ ] yes [ ] no**

Nature of Surgery Hospital Date

_____ _____ _____

_____ _____ _____

Please indicate if you have ever received any of the following testing.

	Date	Result (if known) and facility preformed at
CT Scan (brain)	_____	_____
MRI (brain)	_____	_____
EEG	_____	_____
Neuropsychological Testing	_____	_____

Do you have any of the following medical illnesses?	No.	Yes. Please provide further information
AIDS/HIV		
Blood pressure problem		
Cancer		
Diabetes		
Epilepsy/seizures		
Gastrointestinal		
Head Injury (Head trauma		
Heart disease		

Kidney disease		
Liver disease		
Neurological disease (stroke, neuropathy, headaches etc.)		
Thyroid disease		
Musculoskeletal problems		
Sleep Apnea		
Other		

Do you currently have any of these physical symptoms?	**No**	**Yes. Please provide further information.**
Bleeding or bruising		
Cardiac (heart) problem (heart-racing, chest pain, etc.)		
Diarrhea or constipation		
Dizziness, lightheadedness or fainting		
Feel cold or hot		
Headaches		
Muscle spasms or weakness		
Weight change		
Other		

EMERGENCY CONTACT

Name: _____ Relation:_____ Phone number(s): _____

Patient Signature: _____ Date: _____