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NEW PATIENT QUESTIONNAIRE

PLEASE TAKE THE TIME TO COMPLETE THIS BEFORE YOUR APPOINTMENT, IT IS A STARTING POINT ONLY AND WILL HELP US USE OUR TIME MORE EFFICIENTLY. YOU MAY USE THE BACK OF THE PAGES FOR ADDITIONAL INFORMATION

NAME _____

DATE OF BIRTH _____

PHONE NUMBER _____ ALTERNATE _____

ADDRESS

_____ Apt_____

_____

EMERGENCY CONTACT

NAME _____

PHONE _____

ADDRESS_____

PERSONAL INFORMATION

SINGLE/PARTNERED/MARRIED/DIVORCED/WIDOWED

CHILDREN AND AGES_____

LIVING SITUATION_____

EMPLOYED/SELF EMPLOYED/RETIRED/LOOKING FOR WORK/DO NOT NEED TO WORK

TYPE OF WORK_____

EDUCATIONAL HISTORY (INCLUDING ANY CHILDHOOD RESOURCE ROOM, EXTRA HELP, ETC)_____

_____

_____

WHAT DO YOU ENJOY OUTSIDE WORK?

_____

_____

DO YOU HAVE PETS?

_____

PRESCRIPTION MEDICATIONS YOU CURRENTLY TAKE OR ARE PRESCRIBED

MEDICATION AND DOSE	DATE STARTED	PURPOSE	EFFECT	SIDE EFFECTS

OVER THE COUNTER MEDICATIONS YOU TAKE

MEDICATION AND DOSE	DATE STARTED	PURPOSE	EFFECT	SIDE EFFECTS

HERBAL MEDICATIONS OR SUPPLEMENTS YOU TAKE

MEDICATION AND DOSE	DATE STARTED	PURPOSE	EFFECT	SIDE EFFECTS

PLEASE TELL ME HOW YOU HOPE I CAN HELP YOU/WHAT ARE YOUR GOALS?

CIRCLE ISSUES YOU ARE **CURRENTLY** EXPERIENCING (PAST ISSUES ARE ON THE NEXT PAGE)

INSOMNIA
SLEEPING TOO MUCH
INCREASED APPETITE
STRESS OR COMFORT EATING
FOOD RESTRICTION
VOMITING FOR WEIGHT LOSS
LOSS OF JOY AND PLEASURE IN LIFE -
LOW ENERGY
TOO MUCH ENERGY
FEELING HEAVY "LIKE IN MOLASSES"
DIFFICULTY GETTING SHOWERED OR
BRUSHING YOUR TEETH
POOR CONCENTRATION
GUILT
ANXIETY THROUGH THE DAY
ANXIETY OR PANIC ATTACKS
SIGNIFICANT ISSUES AT WORK
SIGNIFICANT ISSUES SOCIALLY
FEELING SCRUTINIZED
DIFFICULTY IN GROUPS OR CROWDS
NOT TRAVELING DUE TO ANXIETY
SEXUAL SYMPTOMS
RECENT DEATH OR GRIEVING
HEARING VOICES OTHERS DON'T
FORGETFULNESS
INDECISION
TICS
OTHERS _____
_____
_____

IRRITABILITY, LOSING TEMPER, ANGER
EXCESSIVE HAND WASHING
GERM FEARS
OBSESSIVE SYMPTOMS SUCH AS
-COUNTING
-RITUALS
NEED FOR SYMMETRY
NIGHTMARES
INTRUSIVE MEMORIES OR THOUGHTS
FEELING NUMB
SHAME
POOR SELF ESTEEM
THOUGHTS OF ENDING YOUR LIFE
THOUGHTS OF HARMING SOMEONE ELSE
WITHDRAWING FROM FRIENDS OR FAMILY
DRINKING OR USING A SUBSTANCE TO CALM DOWN OR TAKE THE EDGE OFF
FEELING HYPER WITH TOO MUCH ENERGY
IMPULSIVE DECISIONS OR BEHAVIOR
EXCESSIVE SHOPPING OR SPENDING
SEXUAL ACTIVITY YOU REGRET
ABUSE
TIMES OF FEELING "TOO GOOD", "ON TOP OF THE WORLD"
INFIDELITY
CONFLICT WITH YOUR SUPPORT SYSTEM
CAREGIVER FATIGUE
ESTRANGEMENT FROM FAMILY OR FRIENDS
MEDICAL ILLNESS IN FAMILY
CAREER DISSATISFACTION
RECENT MOVE
FINANCIAL ISSUES

CIRCLE ISSUES YOU HAVE EXPERIENCED **IN THE PAST**

INSOMNIA
SLEEPING TOO MUCH
INCREASED APPETITE
STRESS OR COMFORT EATING
FOOD RESTRICTION
VOMITING FOR WEIGHT LOSS
LOSS OF JOY AND PLEASURE IN LIFE -
LOW ENERGY
TOO MUCH ENERGY
FEELING HEAVY “LIKE IN MOLASSES”
DIFFICULTY GETTING SHOWERED OR
BRUSHING YOUR TEETH
POOR CONCENTRATION
GUILT
ANXIETY THROUGH THE DAY
ANXIETY OR PANIC ATTACKS
SIGNIFICANT ISSUES AT WORK
SIGNIFICANT ISSUES SOCIALLY
FEELING SCRUTINIZED
DIFFICULTY IN GROUPS OR CROWDS
NOT TRAVELING DUE TO ANXIETY
SEXUAL SYMPTOMS
HEARING VOICES THAT OTHERS DON’T

IRRITABILITY, LOSING TEMPER, ANGER
EXCESSIVE HAND WASHING
GERM FEARS
OBSESSIVE SYMPTOMS SUCH AS
-COUNTING
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IMPULSIVE DECISIONS OR BEHAVIOR
EXCESSIVE SHOPPING OR SPENDING
SEXUAL ACTIVITY YOU REGRET
ABUSE
TIMES OF FEELING “TOO GOOD”, “ON TOP OF THE WORLD”
TICS

ARE YOU EXERCISING REGULARLY? Y/N

DESCRIBE YOUR DIET

MENTAL HEALTH HISTORY

ARE YOU CURRENTLY SEEING A PSYCHIATRIST? Y/N

NAME AND CONTACT NUMBER

ARE YOU CURRENTLY SEEING A THERAPIST? Y/N

NAME AND CONTACT NUMBER

WHEN DID YOU FIRST RECEIVE PSYCHIATRIC TREATMENT?

WAS IT HELPFUL?

WHAT DIAGNOSES HAVE YOU BEEN TOLD OR WERE USED? DO YOU AGREE?

LIST ANY PAST PSYCHIATRIST OR THERAPISTS YOU HAVE SEEN *(USE REVERSE IF NEEDED)*

NAME	DATES	HELPFUL?

PLEASE LIST ALL OTHER PSYCHIATRIC MEDICATIONS THAT YOU HAVE TAKEN INCLUDING CALMING MEDICATIONS SUCH AS VALIUM, STIMULANTS SUCH AS ADDERALL AND SLEEP MEDICATIONS THAT MAY HAVE BEEN PRESCRIBED BY A NON PSYCHIATRIST OR BORROWED FROM A FRIEND OR FAMILY MEMBER *(USE THE REVERSE SIDE OF PAPER IF NEEDED)*

MEDICATION AND DOSE	RESPONSE	SIDE EFFECTS	APPROXIMATE DATES

HAVE YOU EVER BEEN ADMITTED TO A PSYCHIATRIC HOSPITAL? Y/N

HAVE YOU EVER ATTEMPTED TO END YOUR LIFE? Y/N

MEDICAL HISTORY *(USE REVERSE OF PAGE IF NEEDED)*

PRIMARY CARE PHYSICIAN

_____

DATE OF YOUR LAST PHYSICAL EXAM _____

LAB WORK _____

CURRENT MEDICAL ISSUES AND TREATMENTS

_____

_____

_____

DO YOU SMOKE NOW? Y/N

HAVE YOU SMOKED? Y/N

DO YOU DRINK ALCOHOL? Y/N

HOW MUCH_____ HOW MANY TIMES A WEEK_____

ALLERGIES TO MEDICATION

_____

_____

PAST MEDICAL ISSUES AND SURGERIES, PLEASE INCLUDE DATES

_____

_____

_____

HAVE YOU EVER HAD A SEIZURE? Y/N
PLEASE DESCRIBE ON REVERSE

HAVE YOU EVER HAD A HEAD INJURY,
CONCUSSION OR LOSS OF CONSCIOUSNESS? Y/N
PLEASE DESCRIBE ON REVERSE

DO YOU HAVE ANY GUNS OR OTHER WEAPONS AT HOME? Y/N

FAMILY HISTORY

CANCER?	Y/N
DIABETES?	Y/N
HEART DISEASE OR ATTACKS?	Y/N
STROKES?	Y/N
KIDNEY FAILURE?	Y/N
LIVER FAILURE?	Y/N
-PSYCHIATRIC TREATMENT?	Y/N
-SUBSTANCE ABUSE ISSUES?	Y/N
-HAS ANYONE TRIED OR COMMITTED SUICIDE?	Y/N

OTHER

HAVE YOU KNOWN ANYONE WHO HAS COMMITTED SUICIDE?	Y/N
DO YOU HAVE LEGAL ISSUES NOW OR HAVE YOU IN THE PAST?	Y/N

WHAT ARE YOUR STRENGTHS?

_____

_____

_____

WHAT ELSE SHOULD I KNOW ABOUT YOU?

_____

_____

_____

SIGNATURE _____ DATE_____

THANK YOU FOR COMPLETING. WE WILL REVIEW AND CLARIFY TOGETHER