

Patient Questionnaire

Patient Name _____ DOB _____

Marital Status: single married separated divorced unmarried, committed relationship widowed other

Living Arrangement: alone with family with relatives foster care board & Care nursing home

When did you first notice any signs and symptoms related to this problem? _____

Circle the behaviors that apply to you:

- | | | |
|--|-----------------------------------|--------------------------------|
| Anxiety | Destroyed property | Avoid places/situations |
| Depression | Easily annoyed/irritated/ on edge | Anger |
| Impulsive act before thinking | Distressing dreams/nightmares | Disorganized thoughts |
| Suicidal thought (specify) | Memory Problems/changes | Sexual concerns |
| Physical sexual spouse abuse | Easily distracted/frustrated | Unusual perceptions |
| Difficulty paying attention | Paranoid/suspicious thoughts | Violent thoughts |
| Elevated or Hyper mood | Hallucinations | Delusions |
| Too little or too much sleep | Increased activity level | Weight loss or weight gain |
| Excessive behaviors
(ex: sex, gambling, shopping, computer) | Talking excessively | Racing thoughts |
| Poor appetite or over eating | Restless/agitated | Alcohol/drug problems |
| Anorexia or binging/purging | Panic attacks | High –risk taking behaviors |
| Feeling hopeless | Dizziness | Injuring or harming yourself |
| Fatigue/ loss of energy | Chest pain or shortness of breath | Relationship problems |
| Feeling of worthlessness/guilt | Numbness or tingling sensation | Family Problems |
| Difficulty concentrating | Phobias or fears | Social support Problems |
| Difficulty making decisions | Fear of dying | Work/school problems |
| Lost temper easily or exploded | Obsessions or compulsions | Learning disabilities problems |
| Housing/economic problems | Legal Problems | Withdrawing/ social isolation |
| Hard to control worrying | Hurting others(people/animals) | Started fight or argument |
| | Easily startled | |

Comments/ other information:

Have these interfered with your ability to function? emotionally physically at home at work or school

Explain how _____

Counseling/Psychiatric Treatment History:

	No	Yes	When	Provider Name/ location	For how long?
Counseling/ Psychiatric treatment	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Suicidal Thoughts/ attempts	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Hospitalizations	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Were you abused as a child?	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____

Medical History:

What medications are you taking presently? (Name, Dose) _____

Do you have any known allergies to medication? No Yes
(If so provide allergies and reactions to them) _____

Do you have history of Thyroid disease? No Yes

Do you have history of excessive hair loss/dry skin/feeling cold? No Yes

What were the results of your last physical exam? _____

Do you have any medical problems? (Describe) _____

If any list past surgeries, hospitalizations, serious injuries and head injuries: _____

Circle all that apply to you:

- | | | | |
|----------------|------------------------|------------------|-------------------------------|
| AIDS/HIV+ | Cancer | Hepatitis | Sexually-transmitted diseases |
| Alcoholism | Childhood diseases | Liver Problems | Allergies |
| Chronic Pain | High Blood Pressure | Tuberculosis | Anemia |
| Diabetes | Kidney Problems | Thyroid Problems | Arthritis |
| Drug Abuse | Neurological Disorders | Vision Problems | Asthma |
| Epilepsy | Hearing Problems | Rheumatic Fever | Birth defects |
| Heart Problems | Stroke | Brain Injury | Headaches |

Other (specify) _____

Family/ Childhood History:

	<u>Biological Family History</u>			<u>Adoptive/step/legal guardian medical history</u>		
Substance abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Psychiatric Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Had Thyroid Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Abused Drugs or ETOH	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown

Developmental History:

Highest level of education completed? _____

Were you ever disruptive in class? No Yes

Did anyone ever call you hyperactive? No Yes

Have you ever tried "speed" or "Diet Pills" No Yes

If so did they hype you up or calm you down? hyped me up calmed me down

Are you currently enrolled in school? No Yes

Chemical Use History:

Have you ever abused alcohol or drugs? No Yes

If yes, what do/did you use? _____

Last used when? _____

MENTAL HEALTH DISCLOSURE FORMS

DEPRESSION SCREEN

Over the last 2 weeks, how often have you been bothered by any of the following problems	Not at All	Several Days	More than Half of the Days	Nearly Every Day
Little interest or pleasure in doing things				
Feeling down, depressed or hopeless				
Trouble falling or staying asleep, or sleeping too much				
Feeling tired or having little energy				
Poor appetite or overeating				
Feeling bad about yourself, or that you are a failure or have let yourself or your family down				
Trouble concentrating on things, such as reading the newspaper or watching television				
Moving or speaking so slowly that other people could have noticed, or the opposite- being so fidgety or restless that you have been moving around a lot more than usual				
Thoughts that you would be better off dead or hurting yourself in some way				

TWO QUESTIONS ABOUT YOURSELF

	YES	NO
During the past month, have you often been bothered by feeling down, depressed or hopeless?		
During the past month, have you been bothered by feeling little interest or pleasure in doing things?		

ADULT ADHD Self Report Scale

Check the box that best describes how you have felt and conducted yourself over the past 6 months	Never	Rarely	Sometimes	Often	Very Often
How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
How often do you have difficulty getting things in order when you have to do a task that requires organization?					
How often do you have problems remembering appointments or obligations?					
When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
How often do you fidget or squirm with your hands or feet, when you have to sit down for a long time?					
How often do you feel overly active and compelled to do things, like you were driven by a motor?					

GENERALIZED ANXIETY DISORDER Scale

Over the last 2 weeks how often have you been bothered by the following problems?	Not at All	Several Days	More than Half the Days	Nearly Every Day
Feeling nervous, anxious or on edge				
Not been able to stop or control worrying				
Worrying too much about different things				
Trouble relaxing				
Being so restless that it is hard to sit still				
Becoming easily annoyed or irritable				
Feeling afraid as if something awful might happen				

MOOD QUESTIONNAIRE

Please check one box only for each of the questions below

MANIA

1. Has there ever been a period of time when you were not your usual self and	YES	NO
...you felt good or so hyper that other people thought you were not your normal self, or you were so hyper that you got into trouble?		
...you were so irritated that you shouted at other people or started fights or arguments?		
...you felt much more self confident than usual?		
...you got much less sleep than usual and found that you didn't really miss it?		
...you were much more talkative and /or spoke much faster than usual?		
...thoughts raced through your head and you could not slow your mind down?		
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?		
...you had much more energy than usual?		
...you were much more active and/or did many more things than usual		
...you were much more social or outgoing than usual for example, you telephoned friends in the middle of the night?		
...you were much more interested in sex than usual?		
...you did things that were unusual for you or that other people might have thought were excessive, foolish or risky?		
...spending money got you or your family into trouble?		
2. If you have checked YES to more than one of the above, have you experienced several of these during the same period of time?		

3. How much of a problem did any of these situations cause you like being unable to work, having family, money or legal problems, and/or getting into serious arguments or fights?

- No Problem
 Minor Problem
 Moderate Problem
 Serious Problem