NEW PATIENT QUESTIONNAIRE

PATIENT NAME: ___________________________ DATE:________________________

REASON(S) FOR CONSULTATION:

RECENT STRESSORS OR TRIGGERS:

- ☐ A recent loss or death:
- ☐ Marital difficulties
- ☐ Difficulties with parents
- ☐ Difficulties with children
- ☐ Pregnant
- ☐ Postpartum
- ☐ Job stress
- ☐ School stress
- ☐ Financial stress
- ☐ Physical Health problems
- ☐ Other:__________________

PERSONAL BACKGROUND & INFORMATION

- ADOPTED? ☐No ☐Yes
- BORN IN (location):____________________
- RAISED IN (locations and your age at the time): ____________________
- CHILDHOOD HOME ENVIRONMENT:
  - ❍ Loving (ie, you felt loved and cherished by someone who was responsible for you)
  - ❍ Nurturing
  - ❍ Isolative
  - ❍ Chaotic
  - ❍ Confusing/inconsistent
  - ❍ Abusive. Details:
  - ❍ Other: __________________
- PARENTS' RELATIONSHIP WHILE YOU WERE A CHILD:
  - ❍ Happily Married
  - ❍ Estranged
  - ❍ Fought all the time
  - ❍ Abusive relationship. Details:
  - ❍ Other:____________
- SIBLINGS (your relationship while you were children):
- EARLY CHILDHOOD DEVELOPMENT:
  - ☐ Mother smoked or used drugs or was exposed to chemicals while pregnant with you
  - ☐ Premature Birth
  - ☐ Traumatic Birth
  - ☐ Delayed
    ☐crawling; ☐sitting; ☐standing; ☐walking; ☐self-toileting; ☐speaking full sentences
  - ☐ Difficulties with: ☐learning to read ☐math ☐tolerating noise ☐tolerating touch
    ☐Other issues:____
    ____
- EDUCATION: How were your academic and social experiences in:

	Academic Performance	Social Experience	Any Significant Difficulties?	Degree and Date
Elementary				
Middle School				
High School				
College(s)				
Postgrad				
Other				

- CAREER HISTORY: Please Detail the occupations you have held:

Occupation	Employer	Dates Employed	Reason Left

- INTERPERSONAL RELATIONSHIPS:
  - **Longest romantic relationship**?
  - **Current Marital Status**:
    - Single never married
    - Divorced
      - Number of divorces:_________________________
    - Separated
    - Currently Married to (name):_________________________
      - ☐ Happily Married
      - ☐ Estranged
      - ☐ Argue/bicker all the time
      - ☐ Abusive relationship. Details: ___________________________________

  - **Children/Offspring**:

Name of Child	Gender	Current Age	Detail any problems with your relationship

  - **Friendships**: Please describe how social you are:

  - **Spiritual/Religious Affiliation:**

  - **Cultural Affiliation**:

  - **Current living situation and conditions (check all that apply):**

    I live alone

    I live with the following people

    I drive a car

      - Describe the place in which you live:___________________________

      - Are you comfortable with your place of residence: ☐Yes ☐No

PSYCHIATRIC BACKGROUND

- EVER BEEN ***DIAGNOSED*** WITH A PSYCHIATRIC CONDITION IN THE PAST?

  ☐No ☐Yes -- LIST HERE ***PAST*** PSYCHIATRIC DIAGNOSES:

Diagnosis/Condition/Symptoms you can recall	Age You were Diagnosed	Diagnosing Clinician

- EVER ***HOSPITALIZED*** FOR PSYCHIATRIC REASONS?

  ☐No

  ☐Yes -- LIST HERE ***ANY*** PSYCHIATRICALY-RELATED HOSPITALIZATIONS & EMERGENCY ROOM VISITS :

Dates of Hosp	Hospital Name	Reason for Hospitalization	What was the treatment plan there? Was it effective?

- CHECK IF EVER HAD THE FOLLOWING **TESTS** (PLEASE BRING REPORTS TO YOUR INITIAL CONSULTATION):
  - ☐ Psychodiagnostic Testing
  - ☐ Neurocognitive Testing
  - ☐ Genetic Testing
  - ☐ Brain Imaging:
  - ☐ Electroencephalogram (EEG):
  - ☐ Blood or urine labs In the last 5 years
  - ☐ Other:

- CHECK IF EVER TREATED WITH:
  - ☐ Psychotherapy
    - When and by whom:
    - Type (if known)
    - Was it effective? If so, in what way?
  - ☐ Sleep Deprivation
  - ☐ Neurofeedback
  - ☐ Light Therapy
  - ☐ Cranial Electric Stimulaton (CES)
  - ☐ Transcranial Magnetic Stimulation (TMS)
  - ☐ Electroconvulsive Therapy (ECT)
  - ☐ Other:____

- LIST ALL PSYCHIATRIC MEDICATION YOU HAVE USED **IN THE PAST** (***NOT*** CURRENTLY)

Date Range	Medication	Prescribed for the treatment of:	Side Effects? Please give details.	Effective?

- LIST ALL ***CURRENT*** PSYCHIATRIC ***AND*** NON-PSYCHIATRIC MEDICATIONS, SUPPLEMENTS & HERBS (***CURRENTLY TAKING):***

Medication Name	Strength Per tablet/capsule	How many tablets do you take and when each day?	How long taken?	Side Effects? Please give details.	Effective?

- ARE YOU ALLERGIC TO ANY MEDICATIONS?
  - ☐ No
  - ☐ Yes -- LIST HERE:

MEDICATION	ALLERGIC REACTION

PSYCHIATRIC SYMPTOMS REVIEW

- PLEASE CHECK ☑ COLUMN IF YOU HAVE A HISTORY OF – OR ARE CURRENTLY EXPERIENCING – ANY OF THE FOLLOWING SYMPTOMS:

SAFETY If you are currently having *serious* thoughts of suicide or self-harm, or harming others, such that you cannot wait for an in-person scheduled outpatient consultation, call 911 or go to your nearest emergency room, where you will be able to get immediate in-person psychiatric evaluation and assistance.	**PAST**	**CURRENT**
Thoughts of ending your life.		
Fantasies of death/ not living		
Harming yourself intentionally (cut/burn etc)		
Thoughts of harming other people		
Physically violent behavior		
Suicide attempt		
Do you own or have access to a gun or firearm?		

SLEEP	**PAST**	**CURRENT**
Difficulties falling asleep		
Difficulties staying asleep		
Restless/fitful sleep		
Awakening too early in the morning and then unable to go back to sleep		
Restless, uncomfortable legs when trying to sleep		
Snoring		
Excessive Daytime Sleepiness		
MOOD	PAST	CURRENT
Depressed/Low mood		
Absence of Joy		
Overly pessimistic outlook		
Lack of interest in things you used to enjoy		
Excessive guilt		
Mental slowing		
Scattered, disorganized thinking		
Mental exhaustion		
Physical exhaustion/fatigue		
Heaviness to your limbs		
Difficulties moving		
Difficulties getting out of bed		
Sleeping too much		

MOOD - continued	PAST	CURRENT
Physically restless, difficulties staying still		
Crying excessively		
Disconnected with others you normally are in tune with		
Increased Appetite		
Increased Weight		
Decreased Appetite		
Decreased Weight		
Aches & pains		
A period of time when you feel euphoric, on top of the world, need less sleep, have boundless energy, have racing thoughts, talk too fast, move around too much, and are spinning your wheels in an effort to be super-productive		

ANXIETY	PAST	CURRENT
Fearful		
Avoid specific situations		
Easily overwhelmed		
Rage with loss of control		
Outwardly Irritable		
Restless		
Keyed Up		
Muscle tension		
Panic or anxiety attacks		
Feeling Numb		
Feeling Detached		
Phobias		
Easily startled		
Recurrent Nightmares		
Flashbacks when reminded about a trauma		
Recurrent, senseless, disturbing, intrusive unwanted thoughts or images that repeatedly pop into your mind for which you feel a strong need to perform rituals or mental tasks?		
PERCEPTIONS	Past	Current
Do you hear voices or sounds that others do not?		
Do you see visions that others fail to see?		
Do you believe that people or groups are specifically following or threatening you?		
Do you receive messages specifically for you in media such as newspapers, billboards, TV, or movies?		
Do you feel that you have special powers over others?		
Do you feel that others exert powers over you?		
Do you smell things that others do not?		
EATING & SELF IMAGE	Past	Current
Do you feel you are overweight?		
Do you hate a specific part of your body to the point that it makes you miserable and it distracts you?		
Do you have a restrictive diet?		
Preoccupied with your weight?		
Binge eating?		
Self-induce vomiting ?		

ATTENTION & COGNITION	PAST	CURRENT
Overly Distractible		
Difficulties focusing		
Scattered		
Careless errors		
Lose things frequently		
Almost always late		
Poor listener		
Difficulties completing tasks or projects		
Messy/not organized		
Fidgety		
Feeling internally driven like a motor		
People complain I'm too chatty		
Interrupt people in mid-sentence/finish their sentences for them		
Memory Difficulties		
Neurological	PAST	CURRENT
Experience of burning or numb sensation on a regular basis?		
Seizures/Convulsions		
Migraine Headaches		
Other Headaches		

CURRENT HABITS/ACTIVITIES

IF "YES" Please indicate how much/how frequently you:

- Sleep at Night (on average): ______ hours
- Exercise: ☐None ☐Yes; Please detail here:______________________
- Meditation: ☐None ☐Yes; Please detail here:______________________

SUBSTANCE ABUSE REVIEW:

- Have you ever attended a substance abuse rehabilitation program? ☐Yes ☐No
  Details:
- How many DUI's have you received? _____

  Details:

SUBSTANCES	***Past Abuse*** (detail what ages you were, average serving size, type, frequency and amounts)	***Current*** use (detail average frequency and amounts)	Complications or Withdrawal Reactions?
Caffeine			☐Yes ☐No
Alcohol			☐Yes ☐No
Tobacco			☐Yes ☐No
Marijuana			☐Yes ☐No
Opiates			☐Yes ☐No
Methamphetamine			☐Yes ☐No
Cocaine			☐Yes ☐No
Ecstasy			☐Yes ☐No
Huffing			☐Yes ☐No
Other			☐Yes ☐No
Other			☐Yes ☐No

CHECK/DESCRIBE PAST & PRESENT FORMAL *PHYSICAL* DIAGNOSES

Past	Present	Diagnosis	Description/Details
		SENSORY	
		Hearing Impaired	
		Tinnitus	
		Visually impaired	
		Glaucoma	Type:
		Other	
		RESPIRATORY	
		Asthma	
		COPD	
		Sleep apnea	
		Other	
		CARDIO/CEREBROVASCULAR	
		Heart Disease	Type:
		Hypertension	
		High Cholesterol/Trig	
		Stroke	Type:
		Other	
		NEUROLOGICAL	
		Dementia	Type:
		Headaches	Type:
		Multiple Sclerosis	
		Traumatic Brain Injury	
		Concussion	
		Seizures	Type:
		Other	
		GASTROINTESTINAL UROGENITAL	
		Gastroesophaegeal Reflux (GERD)	
		Stomach ulcer	
		Liver Disease	
		Crohn's Disease	Type:
		Ulcerative Colitis	
		Other	
		UROGENITAL	
		Erectile Dysfunction	
		Bladder Disease	
		Kidney Disease	
		Polycystic Ovarian Syndrome	
		Infertility	
		Other	
		HORMONAL	
		Thyroid Disease	Type:
		Addison's Disease	
		Diabetes	Type:
		Other	
		AUTOIMMUNE DISORDERS	
		Rheumatoid Arthritis	
		Systemic Lupus	
		Other	
		MUSCULOSKELETAL	
		Osteoarthritis	
		Osteopenia	
		Fibromyalgia	
		Other	
		CANCERS	
		Describe Cancer:	
		INFECTIONS (Chronic or serious)	
		Describe infections:	

LIST ANY PRIOR SURGICAL PROCEDURES:

☐**None**
☐**List Procedures:**

ANY TATTOOS, METAL IMPLANTS OR PACEMAKERS, OR DEFIBRILLATORS?

☐**No**
☐**Yes, detailed here:**

MENSTRUATING WOMEN:

- ☐ My last period was:_____________
- ☐ I am actively trying to conceive
- ☐ I use birth control:
  - ❍ Contraceptive pill
  - ❍ Condoms
  - ❍ Diaphragm
  - ❍ Surgical
  - ❍ Other:
- ☐ I am not on birth control and have been sexually active since my last period.
- ☐ I have never had sexual intercourse with a male.
- ☐ I am Breastfeeding.
- ☐ I am Pregnant. (Due Date: ________________)
- ☐ I have been pregnant in the past.

Number of births: ________ Number of pregnancies:________

Number of miscarriages:_______ Number of abortions:_________

REVIEW OF CURRENT *PHYSICAL* SYMPTOMS (ROS):

➢ **MEN & WOMEN: CURRENT PHYSICAL SYMPTOMS ENDORSED:**

GENERAL, CONSTITUTIONAL
- ❍ Recent weight loss
- ❍ Lethargy
- ❍ Fever
- ❍ Chills

EYES, VISION
- ❍ Visual Problems

EARS, NOSE, THROAT
- ❍ Hearing loss
- ❍ Ringing in ears
- ❍ Snoring
- ❍ Teeth clenching/jaw grinding

HEART,CARDIOVASCULAR
- ❍ Chest pain or pressure
- ❍ Arrhythmia or palpitations
- ❍ Shortness of breath
- ❍ Peripheral edema
- ❍ Blood clots
- ❍ Varicose Veins
- ❍ Cramping in thighs

RESPIRATORY
- ❍ Cough
- ❍ Shortness of breath
- ❍ Wheezing

GASTROINTESTINAL
- ❍ Abdominal pain
- ❍ Heartburn
- ❍ Bloody stool
- ❍ Nausea/vomiting

GENITOURINARY
- ❍ Frequent urination
- ❍ Urgency
- ❍ Sexual difficulties:

MUSCULOSKELETAL
- ❍ Joint or muscle pain or swelling:
- ❍ Restricted motion

SKIN & INTEGUMENTARY
- ❍ Rashes
- ❍ Sores
- ❍ Hair loss
- ❍ Dryness
- ❍ Excessive sweating

NEUROLOGICAL
- ❍ Numbness or tingling sensations
- ❍ Sensation loss
- ❍ Burning

ENDOCRINE
- ❍ Heat or cold intolerance
- ❍ Excessive thirst
- ❍ Hot flashes/night sweats

HEMATOL/LYMPHATIC
- ❍ Abnormal bleeding
- ❍ Bruising
- ❍ New growths/masses

ALLERGY/IMMUNOLOGY
- ❍ Allergic reaction
- ❍ Recurrent infections

FAMILY PSCHIATRIC HISTORY:

Please list any history of depression, bipolar, OCD, panic, anxiety, schizophrenia, ADHD, Parkinson’s Disease, Dementia, or other psychiatric, cognitive, behavioral or personality disorders.

		SIGNIFICANT **MENTAL HEALTH** PROBLEMS			SIGNIFICANT **MENTAL HEALTH** PROBLEMS
FATHER			***Children***	☐Daughter ☐Son	
MOTHER				☐Daughter ☐Son	
Sibling	☐Bro ☐Sis			☐Daughter ☐Son	
	☐Bro ☐Sis			☐Daughter ☐Son	
	☐Bro ☐Sis		**GRAND-MOTHER** *Maternal*		
	☐Bro ☐Sis		**GRAND-FATHER** *Maternal*		
	☐Bro ☐Sis		**GRAND-MOTHER** *Paternal*		
	☐Bro ☐Sis		**GRAND-FATHER** *Paternal*		

PLEASE INDICATE AND DETAIL ANY *FAMILY* HISTORY OF:

Suicide Attempt (please detail if the suicide(s) were completed):

Psychiatric Hospitalization:

Substance Abuse:

Other psychiatric diagnoses: