Patient Information

Identifying Information

Client Name: ______________________

Age: ______________________

Race: ______________________

Medications Allergies: ______________________

Occupation: ______________________

PCP: ______________________

Date of Birth: ______________________

Gender: ______________________

Residence (City): ______________________

Marital Status: M D S W

Currently Employed: Y N

Pharmacy #: ______________________

Presenting Problems

Brief Description of Current Problems: ______________________

____

____

Psychiatric Medications (please use an additional page if necessary)

Current:

Med: ____________ Dose: ________ Frequency: ________ Duration: ________

Med: ____________ Dose: ________ Frequency: ________ Duration: ________

Med: ____________ Dose: ________ Frequency: ________ Duration: ________

Med: ____________ Dose: ________ Frequency: ________ Duration: ________

Past: ______________________

Other Medications (to include Vitamins, Herbals, etc.)

____

Past Treatment

Current/Past psychiatric diagnosis: ______________________

Previous Psychiatric Treatment:

In-Patient: When: ____________ When: ____________

Where: ____________ Where: ____________

Why: ____________ Why: ____________

Out-Patient: When: ____________ When: ____________

Where: ____________ Where: ____________

Suicide Attempts: Y N If yes, ______________________

Habits

Tabaco ________ ppd ________ years

Alcohol Current ____________ Past ____________

Caffeine _____cups coffee/day _____colas/day _____glasses of tea/day

Substance Abuse

Please Circle: None Past Present

Substance Used: ____________ Age of Onset: ____________

Amount/Frequency of Use: ____________ Length of Use: ____________

Consequences of Use: ______________________

Medical History
Developmental Delays: Y N If yes, ______________________________
Current/Chronic Illness: Y N If yes, ______________________________
____
Surgeries: Y N If yes, ______________________________
Head Injuries/Seizures: Y N If yes, ______________________________
Difficulties during Delivery/Pregnancy: Y N If yes, ______________________________
Current Nutritional Status: Weight ______________ Height ______________
Female Only: Age of onset of period ____ Last period _____ Birth control ____________
Age of onset of Menopause ____ Hormone replacement ____________

Family History
Medical: Mother side: ______________________________
Father side: ______________________________
Siblings/Children: ______________________________
Psychiatric: Mother side: ______________________________
Father side: ______________________________
Siblings/Children: ______________________________
Alcohol/Substance Abuse:
Mother side: ______________________________
Father side: ______________________________
Siblings/Children: ______________________________

Social History
Current residence (City/State): ______________________________
Name/age of children: ______________________________
#/Duration of Marriages: ______________________________
Who lives in the Home: ______________________________
____

Childhood History
Where were you born and raised: ______________________________
Level of Education: ______________________________
Number of Siblings: Brothers ______________ Sisters ______________

Relationships
Abuse: Physical/Sexual/Emotional Y N If yes, ______________________________
____

Financial Issues: Y N If yes, ______________________________
Legal Issues: Y N If yes, ______________________________

______________________ ______________
Patient Signature Date

I have reviewed with patient and revised as needed the above patient information: Y N

______________________ ______________
Physician Signature Date

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: ______________________ DATE: ____________

Over the last 2 *weeks,* how often have you been bothered by any of the following problems? *(use "✓" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns		+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	
	Not difficult at all ______
	Somewhat difficult ______
	Very difficult ______
	Extremely difficult ______

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Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all __________
Somewhat difficult _________
Very difficult _____________
Extremely difficult _________

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.

Mood Disorder Questionnaire (MDQ)

Instructions:

Please answer each question as best you can.

1 Has there ever been a period of time when you were not your usual self and ...

	Yes	No
– you felt so 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 irritable that you shouted at 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 more talkative or spoke much faster than usual?	☐	☐
– thoughts raced through your head or you couldn't 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 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 in trouble?	☐	☐

2 If you checked YES to more than one of the above, have several of these ever happened during the same period of time? ☐ Yes ☐ No

3 How much of a problem did any of these cause you–like being unable to work; having family, money or legal trouble; getting into arguments or fights?

☐ No problem ☐ Minor problem ☐ Moderate problem ☐ Serious problem

The CAGE Questionnaire Adapted to Include Drugs (CAGE-AID)

1. **Have you felt you ought to cut down on your drinking or drug use?**
2. **Have people annoyed you by criticizing your drinking or drug use?**
3. **Have you felt bad or guilty about your drinking or drug use?**
4. **Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)?**

Score: __ /4

Source: **Reprinted with permission from the *Wisconsin Medical Journal.* Brown, R.L., and Rounds, L.A. Conjoint screening questionnaires for alcohol and drug abuse. *Wisconsin Medical Journal* 94:135-140, 1995.**

Medical Review of Systems

Check next to any symptoms you have experienced recently, or for which you have concerns about.

Name: ______________________

Date: ______________________

BP_____/_____ P____ Ht.______ Wt.______

	General
	Recent unexpected weight loss
	Chronic fatigue
	Anemia
	Lack of regular exercise
	Overweight

	Eyes
	Failing vision
	Eye pain
	Double vision
	Blurred vision
	Frequent eye infections
	Glaucoma
	Cataracts

	Ears, Nose, Mouth
	Decreased hearing
	Ringing in ears
	Frequent ear infections
	Frequent nose bleeds
	Sinus trouble
	Frequent sore throat
	Prolonged hoarseness
	Tooth or jaw pain

	Cardiovascular
	Chest pain
	Dizzy spells
	Fainting spells
	High blood pressure
	Swollen ankles
	Irregular pulse
	Shortness of breath

	Pulmonary
	Pneumonia/pleurisy
	Bronchitis/chronic cough
	Asthma/wheezing

	Gastrointestinal
	Recent loss of appetite
	Difficulty swallowing
	Heartburn/gastritis
	Persistent nausea/vomiting
	Chronic abdominal pain
	Gall bladder trouble
	Jaundice
	Change in appearance of stool
	Diarrhea
	Constipation
	Bloody or very dark stools
	Hemorrhoids
	Hernia

	Genito-Urinary
	Frequent urine infections
	Blood in urine
	Kidney stones
	Painful urination
	Loss of control of urine
	Decrease in flow
	Urination more than 2x per night
	Any venereal disease in the past? (Herpes, Chlamydia, Gonorrhea)

	Musculoskeletal
	Pain in joints
	Pain in muscles
	Recurrent back pains
	Past injury to bones, spine, or joints
	Gout attacks in the past
	Concerned about osteoporosis

	Integumentary
	Skin rashes
	Hives
	Skin moles—black or changing
	Breast mass
	Nipple discharge

	Neurologic
	Frequent headaches
	Tremor/hand shaking
	Muscle weakness
	Numbness/tingling
	Seizures/convulsions
	Difficulty sleeping
	Excessive daytime sleeping
	Memory loss

	Psychological
	Feeling depressed
	Nervous or anxious feeling
	Excessive moodiness
	Difficulty concentrating
	Phobias/unexplained fears
	Loss of pleasure in life

	Endocrine
	Excessive thirst and urination
	Feet and hands numbness/pain
	Low blood sugar problems
	Intolerance to heat or cold

	Hematologic/ Lymphatic
	Excessive bruising
	Swollen glands in neck, armpit, or groin
	Unexplained fever, chills, night sweats

	Allergic/ Immunologic
	Hay fever/allergies
	Acquiring many infections
	Desire HIV discussion

	Substance/Chemical Use
	More than 6 drinks a week
	Tobacco use
	Caffeine use
	Over-the-counter meds/vitamins

	Women Only
	Irregular periods
	Excessive flow/pain
	Hot flashes/night sweats
	Abnormal PAP smear

Anything else you want your doctor to be aware of?

Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

Patient Name		Today's Date	

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.	Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?					
3. How often do you have problems remembering appointments or obligations?					
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?					
					Part A
7. How often do you make careless mistakes when you have to work on a boring or difficult project?					
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
10. How often do you misplace or have difficulty finding things at home or at work?					
11. How often are you distracted by activity or noise around you?					
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?					
13. How often do you feel restless or fidgety?					
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?					
15. How often do you find yourself talking too much when you are in social situations?					
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?					
17. How often do you have difficulty waiting your turn in situations when turn taking is required?					
18. How often do you interrupt others when they are busy?					
					Part B

PCL-C

<u>INSTRUCTIONS</u>: Below is a list of problems and complaints that people sometimes have in response to stressful life experiences. Please read each one carefully, then circle one of the numbers to the right to indicate how much you have been bothered by that problem <u>in the past month</u>.

	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing *memories, thoughts,* or *images* of a stressful experience from the past?	1	2	3	4	5
2. Repeated, disturbing *dreams* of a stressful experience from the past?	1	2	3	4	5
3. Suddenly *acting* or *feeling* as if a stressful experience *were happening again* (as if you were reliving it)?	1	2	3	4	5
4. Feeling *very upset* when *something reminded you* of a stressful experience from the past?	1	2	3	4	5
5. Having *physical reactions* (e.g., heart pounding, trouble breathing, sweating) when *something reminded you* of a stressful experience from the past?	1	2	3	4	5
6. Avoiding *thinking about* or *talking about* a stressful experience from the past or avoiding *having feelings* related to it?	1	2	3	4	5
7. Avoiding *activities* or *situations* because *they reminded you* of a stressful experience from the past?	1	2	3	4	5
8. Trouble *remembering important parts* of a stressful experience from the past?	1	2	3	4	5
9. *Loss of interest* in activities that you used to enjoy?	1	2	3	4	5
10. Feeling *distant* or *cut off* from other people?	1	2	3	4	5
11. Feeling *emotionally numb* or being unable to have loving feelings for those close to you?	1	2	3	4	5
12. Feeling as if your *future* will somehow be *cut short*?	1	2	3	4	5
13. Trouble *falling* or *staying asleep*?	1	2	3	4	5
14. Feeling *irritable* or having *angry outbursts*?	1	2	3	4	5
15. Having *difficulty concentrating*?	1	2	3	4	5
16. Being "*super-alert*" or watchful or on guard?	1	2	3	4	5
17. Feeling *jumpy* or easily startled?	1	2	3	4	5