

Patient Information

Identifying Information:

Client Name: _____

Date of Birth: _____

Age: _____

Gender: _____

Race: _____

Residence (City): _____

Medication Allergies: _____

Marital Status: M D S W

Occupation: _____

Currently Employed: Y N

PCP: _____

Pharmacy #: _____

Presenting Problems:

Brief Description of Current Problems:

Psychiatric medications (use an additional page if necessary)

Current:

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:

Tobacco: _____ 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 Menopause: _____ Hormone replacement: _____

Family History:

Medical: Mother side: _____

Father side: _____

Sibling/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)

ID #: _____

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 fidgety 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, TOTAL:
please refer to accompanying scoring card).

10. If you checked off <i>any problems</i> , how <i>difficult</i> 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	_____

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

2/4 or greater = positive CAGE, further evaluation is indicated

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.

Mood Disorder Questionnaire

Patient Name _____ Date of Visit _____

Please answer each question to the best of your ability

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?	<input type="checkbox"/>	<input type="checkbox"/>
...you were so irritable that you shouted at people or started fights or arguments?	<input type="checkbox"/>	<input type="checkbox"/>
...you felt much more self-confident than usual?	<input type="checkbox"/>	<input type="checkbox"/>
...you got much less sleep than usual and found that you didn't really miss it?	<input type="checkbox"/>	<input type="checkbox"/>
...you were more talkative or spoke much faster than usual?	<input type="checkbox"/>	<input type="checkbox"/>
...thoughts raced through your head or you couldn't slow your mind down?	<input type="checkbox"/>	<input type="checkbox"/>
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	<input type="checkbox"/>	<input type="checkbox"/>
...you had more energy than usual?	<input type="checkbox"/>	<input type="checkbox"/>
...you were much more active or did many more things than usual?	<input type="checkbox"/>	<input type="checkbox"/>
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	<input type="checkbox"/>	<input type="checkbox"/>
...you were much more interested in sex than usual?	<input type="checkbox"/>	<input type="checkbox"/>
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	<input type="checkbox"/>	<input type="checkbox"/>
...spending money got you or your family in trouble?	<input type="checkbox"/>	<input type="checkbox"/>
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	<input type="checkbox"/>	<input type="checkbox"/>

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

No problems Minor problem Moderate problem Serious problem

Medical Review of Systems

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

Name: _____

Date: _____

BP _____ / _____ p _____ Ht _____ Wt _____

General	
<input type="checkbox"/>	Recent unexpected weight loss
<input type="checkbox"/>	Chronic fatigue
<input type="checkbox"/>	Anemia
<input type="checkbox"/>	Lack of regular exercise
<input type="checkbox"/>	Overweight

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

Integumentary	
<input type="checkbox"/>	Skin rashes
<input type="checkbox"/>	Hives
<input type="checkbox"/>	Skin moles – black or changing
<input type="checkbox"/>	Breast mass
<input type="checkbox"/>	Nipple discharge

Hematologic/Lymphatic	
<input type="checkbox"/>	Excessive bruising
<input type="checkbox"/>	Swollen glands in neck, armpit, or groin
<input type="checkbox"/>	Unexplained fever, chills, night sweats

Eyes	
<input type="checkbox"/>	Failing vision
<input type="checkbox"/>	Eye pain
<input type="checkbox"/>	Double vision
<input type="checkbox"/>	Blurred vision
<input type="checkbox"/>	Frequent eye infections
<input type="checkbox"/>	Glaucoma
<input type="checkbox"/>	Cataracts

Neurologic	
<input type="checkbox"/>	Frequent headaches
<input type="checkbox"/>	Tremor/hand shaking
<input type="checkbox"/>	Muscle weakness
<input type="checkbox"/>	Numbness/tingling
<input type="checkbox"/>	Seizures/convulsions
<input type="checkbox"/>	Difficulty sleeping
<input type="checkbox"/>	Excessive daytime sleeping
<input type="checkbox"/>	Memory loss

Allergic/Immunologic	
<input type="checkbox"/>	Hay fever/allergies
<input type="checkbox"/>	Acquiring many infections
<input type="checkbox"/>	Desire HIV discussion

Ears, Nose, Mouth	
<input type="checkbox"/>	Decreased hearing
<input type="checkbox"/>	Ringing in ears
<input type="checkbox"/>	Frequent ear infections
<input type="checkbox"/>	Frequent nose bleeds
<input type="checkbox"/>	Sinus trouble
<input type="checkbox"/>	Frequent sore throat
<input type="checkbox"/>	Prolonged hoarseness
<input type="checkbox"/>	Tooth or jaw pain

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

Psychological	
<input type="checkbox"/>	Feeling depressed
<input type="checkbox"/>	Nervous or anxious feeling
<input type="checkbox"/>	Excessive moodiness
<input type="checkbox"/>	Difficulty concentrating
<input type="checkbox"/>	Phobias/unexplained fears
<input type="checkbox"/>	Loss of pleasure in life

Substance/Chemical Use	
<input type="checkbox"/>	More than 6 drinks a week
<input type="checkbox"/>	Tobacco use
<input type="checkbox"/>	Caffeine use
<input type="checkbox"/>	Over-the-counter meds/vitamins

Cardiovascular	
<input type="checkbox"/>	Chest pain
<input type="checkbox"/>	Dizzy spells
<input type="checkbox"/>	Fainting spells
<input type="checkbox"/>	High blood pressure
<input type="checkbox"/>	Swollen ankles
<input type="checkbox"/>	Irregular pulse
<input type="checkbox"/>	Shortness of breath

Musculoskeletal	
<input type="checkbox"/>	Pain in joints
<input type="checkbox"/>	Pain in muscles
<input type="checkbox"/>	Recurrent back pains
<input type="checkbox"/>	Past injury to bones, spine, or joints
<input type="checkbox"/>	Gout attacks in the past
<input type="checkbox"/>	Concerned about osteoporosis

Endocrine	
<input type="checkbox"/>	Excessive thirst and urination
<input type="checkbox"/>	Feet and hands numbness/pain
<input type="checkbox"/>	Low blood sugar problems
<input type="checkbox"/>	Intolerance to heat or cold

Women only	
<input type="checkbox"/>	Irregular periods
<input type="checkbox"/>	Excessive flow/pain
<input type="checkbox"/>	Hot flashes/night sweats
<input type="checkbox"/>	Abnormal PAP smear

Pulmonary	
<input type="checkbox"/>	Pneumonia/pleurisy
<input type="checkbox"/>	Bronchitis/chronic cough
<input type="checkbox"/>	Asthma/wheezing

Anything else you want your doctor to be aware of?	