PATIENT QUESTIONNAIRE

Please review the following questions and answer each as completely as possible

NAME_____ DATE OF BIRTH_____

BIRTHPLACE_____

WHO REFERRED YOU TO OUR PRACTICE?_____

FAMILY: (List e adjectives to describe each relative and their personalities, i.e. good, kind, stern, domineering)

FATHER'S NAME _____ AGE_____ (living/deceased) If

deceased list the cause of death._____

LOCATION _____ OCCUPATION_____

GENERAL HEALTH: ____GOOD _____ FAIR _____ POOR ____ UNKNOWN

LIST 3 ADJECTIVES TO DESCRIBE:

1_____ 2_____ 3_____

PARENTAL GRANDFATHER _____ AGE_____(living or deceased) If

deceased list the cause of death. _____

LOCATION _____ OCCUPATION_____

GENERAL HEALTH: ____GOOD _____ FAIR _____ POOR ____ UNKNOWN

LIST 3 ADJECTIVES TO DESCRIBE:

1_____ 2_____ 3_____

PATERNAL GRANDMOTHER_____ AGE_____(living /deceased) If

deceased list the cause of death._____

LOCATION _____ OCCUPATION_____

GENERAL HEALTH: ____GOOD _____ FAIR _____ POOR ____ UNKNOWN

LIST 3 ADJECTIVES TO DESCRIBE:

1_____ 2_____ 3_____

LIST AUNTS AND UNCLES ON YOUR FATHER'S SIDE OF THE FAMILY. Describe each using 3 adjectives.

NAME AGE DESCRIPTION

1_____
2_____
3_____
4_____
5_____
6_____
7_____
8_____

MOTHER'S NAME _____ AGE_____ (living/deceased)

If deceased list the cause of death._____

LOCATION _____ OCCUPATION_____

GENERAL HEALTH: ____GOOD _____ FAIR _____ POOR ____ UNKNOWN

LIST 3 ADJECTIVES TO DESCRIBE:

1_____ 2_____ 3_____

MATERNAL GRANDFATHER _____ AGE_____(living or deceased) If

deceased list the cause of death. _____

LOCATION _____ OCCUPATION_____

GENERAL HEALTH: ____GOOD _____ FAIR _____ POOR ____ UNKNOWN

LIST 3 ADJECTIVES TO DESCRIBE:

1_____ 2_____ 3_____

MATERNAL GRANDMOTHER_____ AGE_____(living /deceased) If

deceased list the cause of death._____

LOCATION _____ OCCUPATION_____

GENERAL HEALTH: ____GOOD _____ FAIR _____ POOR ____ UNKNOWN

LIST 3 ADJECTIVES TO DESCRIBE:

1_____ 2_____ 3_____

LIST AUNTS AND UNCLES ON YOUR MOTHER'S SIDE OF THE FAMILY. Describe each using 3 adjectives.

	NAME	AGE	DESCRIPTION
1			
2			
3			
4			
5			
6			
7			
8			

SIBLINGS: Please list all brothers and sisters from oldest to youngest, including yourself. Indicate whether the sibling is full, half, step or adopted. Please describe using 3 adjectives.

	NAME	AGE	DESCRIPTION
1			
2			
3			
4			
5			

How many of your blood relatives (including aunts, uncles and cousins) have experienced problems with depression, anxiety, phobias, drugs and alcohol, or been treated by a professional in the mental health field? Please List:

	NAME	RELATION	PROBLEM
1			
2			
3			
4			
5			

Is there anyone in your family who has a history of violent behavior, suicide, multiple arrests or prison terms? Please List.

1_____
2_____
3_____
4_____
5_____

Has anyone in your family had multiple marriages and divorces? Please list:

1_____
2_____
3_____

PERSONAL HISTORY

Present Marital Status: ___single _____ married _____divorced _____ widowed

How many times have you been married? _____

Please list all Marriages:

DATE FROM TO SPOUSE'S NAME REASON FOR TERMINATION

1_____

2_____

3_____

NUMBER OF CHILDREN _____

Please list all of your children and indicate whether child is natural child, step-child or adopted:

	NAME	AGE	Location	Natural	Step	Adopted
1						
2						
3						
4						
5						

HISTORY OF CHILDREN

Did any of your children experience the following:

A Learning Disorder _____

Hyperactivity in Childhood _____

Anxiety about Speaking in Public _____

Unreal Fears or Unusual Fears _____

PLEASE LIST ANY HOBBIES OR SPECIAL INTERESTS:

1 _____

2 _____

3 _____

WHAT IS YOUR RELIGIOUS PREFERENCE? _____

HOW OFTEN DO YOU ATTEND RELIGIOUS SERVICES?_____

ARE YOU CURRENTLY UNDER INVESTIGATION FOR ANY CRIME? _____

HAVE YOU EVER BEEN ARRESTED FOR ANY REASON? _____

HAVE YOU EVER BEEN IN PRISON? _____

PLEASE EXPLAIN: _____

_____

EDUCATIONAL BACKGROUND

HOW MANY YEARS OF FORMAL EDUCATION DO YOU HAVE? _____

DID YOU COMPLETE:_____High School _____Technical School _____ College

_____Graduate/Professional School

DID YOU HAVE ANY UNUSUAL PROBLEMS LEARNING IN SCHOOL: _____. If yes please explain.

_____

_____

ARE YOU PRESENTLY ATTENDING SCHOOL? _____

WHAT IS THE NAME OF THE SCHOOL YOU LAST ATTENDED? _____

FROM WHAT HIGH SCHOOL AND/OR COLLEGE DID YOU GRADUATE? _____

_____

OCCPATIONAL/FINANCIAL INFORMATION

WHAT IS YOUR CURRENT OCCUPATION? _____
HOW LONG HAVE YOU BEEN AT THIS POSITION? _____
WHO IS YOUR EMPLOYER? _____
HOW MANY HOURS DO YOU WORK IN AN AVERAGE WEEK? _____
HOW MANY DAYS HAVE YOU MISSED IN THE LAST MONTH? _____
LAST YEAR? _____
ARE YOU SATISFIED WITH YOUR PRESENT POSITION? _____
IF NOT, WHY? _____
_____
_____

HOW MANY EMPLOYERS HAVE YOU HAD IN THE PAST 5 YEARS? _____

If more than one, please list.

	EMPLOYER	FROM	TO	REASON FOR LEAVING
1				
2				
3				
4				
5				

IS YOUR SPOUSE EMPLOYED OUTSIDE THE HOME? _____
WHAT IS YOUR SPOUSE'S OCCUPATION? _____
WHO EMPLOYS YOUR SPOUSE? _____
ARE YOU ARE YOUR SPOUSE PRESENTLY DISABLED OR RECEIVING WORKERS COMPENSATION? _____
PLEASE EXPLAIN: _____
_____
_____
PLEASE ESTIMATE YOUR ANNUAL HOUSEHOLD INCOME _____
ARE YOU EXPERIENCING ANY MAJOR FINANCIAL PROBLEMS? _____
PLEASE EXPLAIN: _____
_____
_____
HAVE YOU EVER FILED PERSONAL BANKRUPTCY? _____

MEDICAL HISTORY

WHO IS YOUR FAMILY PHYSICIAN? _____
HOW MANY TIMES IN THE LAST YEAR HAVE YOU CONSULTED A PHYSICIAN? PLEASE LIST:

	PHYSICIAN	PROBLEM	DATE
1			
2			
3			
4			
5			

PLEASE LIST ALL MEDICATIONS WHICH YOU CURRENTLY TAKE.

	MEDICATION	DOSE	TIMES PER DAY TAKEN	PRESCRIBER
1				
2				
3				
4				
5				

DO YOU HAVE ANY ALLERGIES? PLEASE LIST.

1 _____

2 _____

3 _____

HAVE YOU BEEN IN THE HOSPITAL OVERNIGHT IN THE LAST 5 YEARS?

	HOSPITAL	FROM	TO	REASON
1				
2				
3				

ARE THERE ANY DISEASES OR ILLNESSES WHICH SEEM TO RUN IN YOUR FAMILY SUCH AS DIABETES, HEART DISEASE, OR HOGH BLOOD PRESSURE?

1 _____

2 _____

3 _____

HAVE YOU EVER SEEN A PSYCHIATRIST, PSYCHOLOGIST OR COUNSELOR BEFORE? PLEASE LIST.

	NAME	FROM	TO	PROBLEM
1				
2				
3				

HAVE YOU EVER HAD TO TAKE ANY NERVE PILLS, TRANQUILIZERS, ANTIDEPRESENTS OR SEDITIVES BEFORE? PLEASE LIST.

	DRUG	DOSE	REASON
1			
2			
3			

HAVE YOU EVER BEEN HOSPITILIZAED FOR NERVE PROBLEMS, DEPRESSION OR ANXIETY? PLEASE LIST:

	HOSPITAL	DATE	DOCTOR	PROBLEM
1				
2				
3				

	DRUGS YOU RECEIVED AT THE HOSPITAL	DOSE	REASON
1			
2			
3			

DO YOU CURRENTLY SMOKE? _____

HAVE YOU EVER SMOKED? _____

IF YES , HOW LONG HAS IT BEEN SINCE YOU SMOKED? _____

DO YOU USE ALCOHOL? _____ IF YES, HOW FREQUENTLY? _____

HAS THE USE OF ALCOHOL EVER CAUSED PROBLEMS IN YOUR PERSONAL OR PROFESSIONAL LIFE? _____

CURRENT SITUATION

WHAT PROBLEM BOTHERS YOU MOST AS THE PRESENT TIME? _____
_____

PLEASE CHECK THE SYMPTOMS BELOW WHICH CURRENTLY BOTHER YOU OR HAVE BOTHERED YOU IN THE LAST SIX MONTHS. CHECK ALL THAT APPLY.

_____Sleep Disturbances
_____ If yes, difficulty going to sleep
_____ Awakening throughout the night
_____ Early morning awakening
_____ Are you blue, sad, despondent
_____ Lack energy
_____Are you interested in your usual pastimes?
_____Have you lost weight?
_____ Have you lost interest in sex?
_____ Do you experience pleasure?
_____Have you thought that you are more energetic than usual?
_____ Have you experienced a decrease in concentration?
_____ Do your thoughts run quickly from topic to topic?
_____ Are you experiencing racing thoughts?
_____ Do you have thoughts or fear of others?
_____ Do you have trouble speaking in public to groups?
_____ Do you have a racing pulse?
_____ Do you have episodes of shortness of breath?
_____ Have you ever thought you would go crazy or lose control?
_____ Do you have difficulty crossing bridges over water?
_____ Do you have difficulty in elevators?
_____ Do you have difficulty flying?
_____ Do you have difficulty standing on a balcony or high rise?
_____ Are you ever compelled to do something that seems silly, i.e. repeatedly count things for example?
_____ Do you ever experience a thought that you cannot seem get out of your mind?
_____ Do you find yourself consuming huge amounts of sweets or starches at one time?
_____ Do you collect things?
_____ Do you double check doors, appliances or locks when leaving your home?

COMORBID STATES QUESTIONNAIRE

Please check all that apply

_____ My brain never shuts off.
_____ I think about the same thing over and over without coming to a conclusion.
_____ My thoughts go so fast that I can't keep up with them when I talk.
_____ I can think of many things at the same time.
_____ If I panic my mind gets full of thought.
_____ I often lose my chain of thought.
_____ When I lay down at night I sometimes can't stop thinking about my problems.
_____ If I awaken at night I sometimes cannot stop thinking about my problems.
_____ I often feel as if something bad is going to happen.
_____ I often feel "on guard" for no reason.
_____ I sometimes feel as though I am watching myself when I say and do things.
_____ I sometimes lose control of what I am saying or doing.
_____ Sometimes I get so anxious it is as if I am watching myself, and say and do things I really don't want to say or do but have no control over myself.
_____ I sometimes can read the same page over and over again and still not know what I read.
_____ I can go from one room to another and forget why I went there.
_____ I have difficulty feeling my emotions.
_____ I have trouble feeling closeness or love.
_____ I have trouble responding emotionally and physically during sex.
_____ I often feel empty inside.
_____ I have trouble knowing what is the right thing for me to do.
_____ When I get scared my hearing and sight get more sensitive.
_____ When I get scared the noises in the room get louder and louder.
_____ When I get scared I hear everything about me loudly and at the same time, everything gets intense and sometimes it's more than I can stand.
_____ I hate loud clocks.
_____ I am easily startled.
_____ It is often my fault when things go wrong.
_____ I often feel sad.
_____ I have little energy.
_____ I feel numb inside when good things happen.
_____ When I feel sad I have I have an empty ache in my chest.
_____ I am easily irritated.
_____ I lose control of my temper.
_____ My feelings can go from happy to sad to happy or peaceful to rage in a flash.
_____ I am sometimes mad without knowing why.
_____ I feel nervous without knowing why.
_____ I keep getting anxious about the same things over and over.
_____ I have trouble talking in front of groups of people.
_____ When I get anxious my mind goes blank.
_____ I am more anxious than I was five years ago.
_____ When I get nervous I feel as if I have electricity in my body.
_____ Thoughts pop into my mind from nowhere.
_____ I can't seem to get over some of the things that have happened.
_____ My hands and feet get cold when I am scared.
_____ My hands are often wet with sweat.
_____ I sweat more than most people.
_____ When I am embarrassed oftentimes I turn beet red and sweat a lot.
_____ I sometimes get rashes on my neck and chest that don't itch and go away.
_____ My blood pressure goes up when I am scared.
_____ I can often feel my heart pounding.
_____ I often have diarrhea when I am anxious.
_____ Doctors often ask me about my thyroid.
_____ I have small pupils.
_____My pupils are larger than most people's.

_____ I have night sweats.
_____ I have migraine headaches.
_____ When I am tense I "lock" my jaw.
_____ I grind my teeth at night.
_____ I feel clumsy a lot of the time.
_____ I get comments on how big my eyes are.
_____ I have trouble going to sleep and staying asleep.
_____ I wake up several times at night.
_____ I sleep well for several hours then sleep poorly for the rest of the night.
_____ I sleep too much.
_____ I come out of sleep quickly.
_____ I have always been overactive.
_____ My symptom started after puberty.
_____ My symptoms started after my child's birth.
_____ My symptoms started (or worsened) after a stressful period in my life.
_____ I cannot take steroids or birth control pills.
_____ I was prescribed stimulants as a child and they were helpful.
_____ Stimulants made me feel more anxious.
_____ Antidepressants made me feel better.
_____ Antidepressants helped me for awhile then lost their effect.
_____ Antidepressants make me more anxious.
_____ Antidepressants made the emptiness inside me worse.
_____ I sometimes drink alcohol to make me feel better.
_____ I sometimes use marijuana to help with anxiety.
_____ Marijuana slows my racing thoughts.
_____ I have had a high sex drive for periods of my life.
_____ I have had times in my life when I felt really good.
_____ I get irritable before my period.
_____ I have thoughts of committing suicide.
_____ I have cut myself before and not felt pain.
_____ I have had troublesome "hot flashes".
_____ I seem to be more "cold natured" than most people.
_____ I have been told that I have "restless leg" syndrome.
_____ I often find myself shaking one or both legs when I sit still.
_____ I have a hard time sitting still. I am more comfortable moving and doing something.

PLEASE CHECK ANY OF THE FOLLOWING SERINOS THAT YOU HAVE EXPERIENCED AT SOME TIME IN YOUR LIFE.

_____ 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 you didn't really miss it.
_____ You were much 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.
_____ You spent money that got you or your family in trouble.

Please read the following statement and sign below

Sleep, anxiety or an inability to concentrate may be treated with controlled substances such as Xanax or Ritlin. When these drugs are misused there are possible dangers of accidents, seizures, accidental overdoses and toxic effects (such as when these medications are used in large doses, mixed with alcohol, marijuana or illegal drugs and even medications prescribed for blood pressure, pain and allergies) These medications, when used, can interfere with the metabolism of other medications and cause potentially dangerous inter-reactions. To prevent problems the following policies will be followed:

Controlled substances will not be prescribed or refilled on weekends. A 48-hour notice is required to obtain the records, call pharmacy or write the prescription for any medication and this cannot be done on the weekend. If a sedative drug is needed, a non-controlled medication such as Neurontin or an anticonvulsant will be prescribed.

If a patient loses or has a prescription for a controlled substance stolen, or the medication itself lost or stolen, he or she may be discharged from the practice. If there is evidence of overuse, misuse, failure to keep appointments, or an inability of a patient to control their use, no further prescriptions for controlled substances will be given: instead an anticonvulsant such as Neurontin may be prescribed to prevent withdrawal. Losing two prescriptions or repeated requests for early refills may result in a patient being discharged from the practice.

Controlled medications are clearly labeled as such on the prescription label and you should ask your physician or your pharmacist if you have any questions. No prescriptions for opiate-like pain medications will be prescribed. A patient should contact their primary care physician or a pain center for such medications.

Signature of Patient (or patient representative):_____

Date:_____ Witnessed by:_____