UPPER VALLEY OUTPATIENT BEHAVIORAL HEALTH

Adult Initial Patient Questionnaire

DATE: _____

DEMOGRAPHICS

PATIENT NAME: _____ **DOB**: _____

PARENT/GUARDIAN: _____

REFERRAL

REFERRED BY: _____

ADDRESS: _____ **PHONE #**: _____

PRESENTING PROBLEMS

WHAT BRINGS YOU TO TREATMENT:

_____

_____

_____

WHEN DID YOU FIRST NOTICE THE PROBLEM: _____

_____

WHAT ARE YOUR PERSONAL OBJECTIVES YOU HOPE TO ACCOMPLISH FROM TREATMENT: _____

_____

PRIOR PSYCHIATRIC TREATMENT (include Inpatient/Outpatient)

Inpatient Facility	**Reason for Treatment**	**Admission & Discharge Dates**	**Physician**
DOCTOR/COUNSELOR Outpatient	**Location & Phone No.**	**Reason for Treatment**	**Frequency**

SUBSTANCE ABUSE HISTORY

_____ y _____ N Does patient drink alcohol? Type and how much? _____

_____ y _____ N Is patient using illegal drugs or abusing prescription medications?

If Yes, please list_____

If applicable, what is the longest time you have gone without using drugs or alcohol? _____

_____ y _____ N Do you have a family member who has, or had, a drug or alcohol problem?

If yes, please identify the problem area and the person's relationship to patient _____

_____

PSYCHOSOCIAL HISTORY

SIGNIFICANT OTHERS (Spouse, children, extended family, etc.)

Please mark an "X" in the box at the left if this person resides with the patient.

X	Relationship	Name	Age	Comments (e.g. Visitation, occupation)

Where did you grow up? _____

How many brothers and sisters do you have? _____

Where are you in the family constellation (i.e. first, middle, youngest)? _____

_____ y _____ N Did your parents divorce? If yes, how old were you and did they remarry? _____

_____

_____ y _____ N Are you married now? If yes, for how long? _____

Do you have any children? If yes, how many and what are their ages? _____

_____

Whom do you believe supports and encourages you? Please identify relationship(s): _____

_____

Major Events & Stressors/Family Functioning-*include impact to patient and family caused by:* *Psychiatric, drug and alcohol and legal problems of patient and family members, illnesses, losses, death and other traumatic events, parental separations, divorces, remarriages and communication/visitation of non-custodial parent.*

_____

_____

FAMILY BEHAVIORAL HEALTH HISTORY

Paternal Side of Family-Biological:

_____Y _____ N Psychiatric Illness and Treatment _____

_____Y _____ N Alcohol/Drug Abuse _____

_____Y _____ N Family Violence _____

_____Y _____ N Criminal Incarcerations _____

Maternal Side of Family-Biological:

_____Y _____ N Psychiatric Illness and Treatment _____

_____Y _____ N Alcohol/Drug Abuse _____

_____Y _____ N Family Violence _____

_____Y _____ N Criminal Incarcerations _____

Siblings/Children:

_____Y _____ N Psychiatric Illness and Treatment _____

_____Y _____ N Alcohol/Drug Abuse _____

_____Y _____ N Family Violence _____

_____Y _____ N Criminal Incarcerations _____

MEDICAL HISTORY

_____Y _____ N **DEPRESSION/SELF-HARM/SUICIDE**

Note: Indicate INTENSITY AND DURATION of symptoms if applicable.

_____Y _____ N Depressed mood/hopelessness:_____

_____Y _____ N Low self-esteem/ worthlessness:_____

_____Y _____ N Frequent crying episodes:_____

_____Y _____ N Sleep Disturbance: Falling asleep Staying asleep Early AM awakening Restlessness

Excessive time in bed Decreased need for sleep (mania)_____

_____Y _____ N Appetite change: Decreased Increased _____

_____Y _____ N Weight change: Gain Loss _____lbs. Current weight_____ Height _____

DEPRESSION/SELF-HARM/SUICIDE Cont.

_____Y _____ N Fatigue, low energy _____

_____Y _____ N Low concentration/indecisive _____

_____Y _____ N Agitated mood/Irritable _____

_____Y _____ N Excessive guilt _____

_____Y _____ N Past suicide attempts, acts of self-harm, or recurrent thoughts of death/suicide?

_____Y _____ N Has the patient thought about suicide or wished he/she was dead? (within past 48 hours)

_____Y _____ N Has patient engaged in any self-harmful behavior? (within past 48 hours)

_____Y _____ N Does patient have a suicide plan?

_____Y _____ N Was this evaluation precipitated by a self-harm act/thought?

_____Y _____ N Can patient contract for safety?_____

_____Y _____ N **MANIA/ANXIETY**

Note: Indicate INTENSITY AND DURATION of symptoms, if applicable

_____Y _____ N More talkative than usual or pressure to keep talking_____

_____Y _____ N Elevated or expansive mood (*mania)*_____

_____Y _____ N Increase in goal-directed activities_____

_____Y _____ N Excessive involvement in pleasurable activities with potential for painful consequences (e.g. sexual promiscuity, drug use, reckless spending) _____

_____Y _____ N Flight of ideas/Racing Thoughts _____

_____Y _____ N Anxiety/Excessive worry/Panic _____

_____

_____Y _____ N Worries about social interaction _____

_____Y _____ N **POST TRAUMATIC STRESS DISORDER- (PTSD)**

Note: Indicate INTENSITY and DURATION of symptoms, if applicable

_____Y _____ N Exposure to traumatic event(s)

_____Y _____ N Recurrent, distressing dreams of traumatic events, flashbacks

_____Y _____ N Feelings of detachment from others

Additional PTSD comments:_____

_____

_____Y _____ N **HOMICIDE-VIOLENCE/LEGAL CHARGES**

Note: Indicate INTENSITY and DURATION of symptoms if applicable

_____ Y _____ N History of legal charges (circle): **Current** **Pending** **Past** Please Explain _____

_____

_____

_____ Y _____ N History of incarceration? Where and When: _____

_____

_____ Y _____ N History of being on probation? Where and When: _____

_____

_____ Y _____ N Has patient EVER had violent/assaultive behavior towards other? _____

_____

_____Y _____ N Has patient had homicidal/violent *thoughts* towards others (in the past 48 hours): _____

_____

_____Y _____ N Has patient had violent/assaultive *behaviors* towards others (in the past 48 hours): _____

_____ Y _____N **Compulsive behaviors:**_____

_____Y _____ N **Psychotic preoccupations/delusions:** guilt worthlessness religious acts somatic comps

Sex death/suicide violence paranoia persecution thought broadcasting Ideas of reference

thought control/influencing others _____

_____Y _____ N **Obsessive thoughts:**_____

_____Y _____ N **Visual hallucinations:** _____

_____Y _____ N **Auditory hallucinations:** _____

CURRENT HEALTHCARE:

Please list any Specialists involved in your healthcare:

Physician's Name(s)_____

Specialty_____

What condition(s) are you being treated for? _____

Please list any allergies/medication allergies_____

PREGNANCY AND BIRTH CONTROL:

_____Y _____ N Are you currently pregnant or attempting to become pregnant?

_____Y _____ N If you are of child bearing age do you use birth control? If so what type? _____

CURRENT AND PAST PROBLEMS OR CONDITIONS:

Please list all medical conditions_____

_____

_____Y _____ N Are you being treated for these conditions?

_____Y _____ N Are you currently experiencing and medical symptoms or problems that you have not been treated or seen by a physician for? Please list_____

Please list any serious health issues that occurred in the past_____

_____

_____Y _____ N Have you ever had any head injuries with loss of consciousness? If yes, please explain_____

_____

_____Y _____ N Do you have a history of seizures?

NUTRITIONAL ASSESSMENT:

_____Y _____ N Diet restrictions? If yes, please explain_____

_____Y _____ N Appetite change? If yes, please explain_____

_____Y _____ N Have you had a recent, unexplained weight gain or loss in the past 3 months? If yes, please explain

_____

_____Y _____ N History of Anorexia _____Y _____ N History of Bulimia _____Y _____ N Binge Eating

PAIN ASSESSMENT:

_____Y _____ N Do you have any current or recent pain? If yes, please explain _____

_____

On a scale from (1) least severe to (10) most severe, please rate you level of pain_____

What pain management techniques do you use? _____

OTHER:

_____Y _____ N Do you use any aids to walk?(ex. Cane, walker, wheelchair)_____

_____Y _____ N Do you have a home health-aide or nurse? If yes, for what condition? _____

_____

_____Y _____ N Do you wear dentures or partials, or have any dental problems? If yes, please explain_____

_____

_____Y _____ N Have you had any past surgeries? If yes, please explain_____

_____

_____Y _____ N Do you have any surgeries scheduled in the near future? If yes, explain_____

_____

EDUCATION

What is your highest grade/degree completed for education? _____

Please specify any specialized training: _____

What is your preferred learning style? Please check all that apply:

_____ Written materials _____ Demonstration _____ Video _____ Discussion

Other_____

CURRENT MEDICATIONS:

Please include any over the counter medications

MEDICATION	DOSE & FREQUENCY	DATE STARTED	LAST DOSE	PRESCRIBED BY

_____Y _____ N **Is patient compliant with taking medications as ordered?**

PHARMACY NAME AND PHONE #_____