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New Patient Intake Screener

Date:_____

Symptom Screener

Patient Name:_____

Over the last 6 MONTHS how often have you experienced the following problems?

Not At All	Several Days	Most Days	Nearly Every day	
				Feeling down, depressed or hopeless
				Little interest or pleasure in doing things
				Feeling Nervous, anxious or on edge
				Not being able to stop or control worrying

Yes	No	
		Have you had an occurrence when all of a sudden you felt frightened, anxious or very uneasy?
		Have you had an occurrence when for no reason your heart suddenly began to race, you felt faint, or you couldn't catch your breath?
		Did any of these occurrences happen in a situation when you were not in any danger or the center of attention?

Not at all	A little Bit	Somewhat	Very Much	Extremely	
					Fear of embarrassment causes me to avoid doing things or speaking to others
					I avoid activities in which I am the center of attention
					Being embarrassed or looking stupid are among my worst fears

Yes	No	**Have you experienced any of the following at any time in your life:**
		Natural Disaster, Fire, explosion, industrial accident, transportation accident, physical or sexual assault, captivity or exposure to a war zone, life threatening illness or injury, sudden unexpected death or injury someone close to you, or serious injury, harm or death to someone else that you witnessed or caused?
		Has this event caused any significant problems or symptoms that lasted for more than a month?

Yes	No	**Has there ever been a period of time when you were NOT your usual self and you felt the followin**
		Felt so good/ hyper that other people thought you were not your normal self or hyper that got you into trouble?

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Yes	No	
		Were so irritable that you shouted at people or started fights or arguments?
		Felt much more self-confident than usual?
		You got much less sleep than usual but found you didn't miss it?
		You felt much more talkative or spoke faster than usual?
		Thoughts racing through your head that you couldn't slow down?
		Felt so easily distracted by things around you that you had trouble concentrating?
		You had much more energy than usual?
		You were much more active or did more things than usual?
		You were much more social or outgoing than usual?
		You were much more interested in sex than usual?
		You did things that were unusual for you that other people might have thought were excessive, foolish o risky?
		Spent money that got you or your family into trouble?

The following questions relate to your <u>eating</u> habits:

Yes	No	
		When you eat, do you MAKE yourself sick because you feel uncomfortably full?
		Do you ever worry that you have lost control over how much you eat?
		Have you recently lost more than 14 pounds in a 3 month period?
		Do you believe yourself to be fat when others say you are too thin?
		Would you say that food dominates your life?

Yes	No	
		Have you ever been bothered by having to perform some ritual or act over and over that does not make sense?

The following questions are related to your <u>alcohol & substance use</u>:

Never	Monthly or less	2-4x a month	2 – 3x a week	4 or more x a week	
					How often do drink Alcohol?

1 – 2	3 – 4	5 – 6	7 – 9	10 or more	
					How many drinks do you have?

Never	Less than monthly	Monthly	Weekly	Daily	
					How often do you have 6 or more drinks on 1 occasion?

Yes	No	In the past year…
		Have you used an illegal drug or used prescription medication for NON – medical reasons?

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How often have you had any of the following in the last 6 months:

Never	Rarely	Sometimes	Often	Very Often	
					Trouble wrapping up the final details of a project?
					Difficulty getting things in order when organization is required?
					Problems remembering appointments or obligations?
					When you have a task that requires a lot of thought, how often do you avoid or delay getting started?
					Do you fidget or squirm w/ your hands/feet when you have to sit for a long period of time?
					How often do you feel overly active & compelled to do things?

Please answer the following based on how you feel your 'usual' self (without symptoms):

Yes	No	
		Do you find that most people will take advantage of you if you let them know too much about you?
		Do you generally feel nervous or anxious around people?
		Do you avoid situations where you have to meet new people?
		Do you avoid getting to know people because you're worried that they may not like you?
		Has avoidance of getting to know people for fear of being disliked affected the # of friends you have?
		Do you change the way you present yourself to others because you don't know who you really are?
		Do you often feel like your beliefs change so much that you don't know what you believe anymore?
		Do you often get angry or irritated because people don't recognize your special talents/ achievements as much as they should?
Yes	No	**In general, at any time…**
		Have you had any unusual experiences such as hearing voices, seeing visions, or having ideas you later found out were not true?
		Have you had any unusual experiences such as mind reading, thoughts being controlled by others, seeing things on TV that refer to you specifically?

Patient Health Questionnaire

Over the last 2 weeks, how often have you been bothered by any of the following:

Never	Several Days	Most Days	Every Day	
				Little to no interest or pleasure in performing everyday tasks
				Feeling down, depressed or hopeless
				Trouble falling asleep, staying asleep, oversleeping
				Feeling tired or having little energy
				Poor appetite or overeating
				Feeling bad about yourself, letting others down, failure to self/family
				Trouble concentrating such as reading or watching tv
				Moving/ speaking slowly or feeling fidgety/restless & others have noticed
				Thoughts that you would be better off dead or hurting yourself in some way

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Generalized Anxiety Questionnaire

Over the last 2 weeks, how often have you been bothered by any of the following:

Not at all	Several Days	Most Days	Every Day	
				Feeling nervous, anxious or on edge
				Not being able to stop or control worrying
				Worrying too much about different things
				Trouble relaxing
				Being so restless that it is hard to sit still
				Becoming easily annoyed or irritable
				Feeling afraid as if something awful might happen

Adult Self Report Scale

How often in the <u>last 6 months</u> have you experienced any of the following:

Never	Rare	Some	Often	VERY Often	**How often do you….**
					Have trouble wrapping up the final details of a project once challenging parts are complete?
					Have difficulty getting things in order when you have a task that requires organization?
					Have problems remembering appointments or obligations?
					Delay or avoid getting started on a task that requires a lot of thought?
					Fidget or squirm w/ hands/feet when sitting for long periods of time?
					Feel compelled to do things, as if driven by a motor/ you HAVE to do it
					Make careless mistakes when working on a boring or difficult project?
					Difficulty keeping attention when doing boring or repetitive work?
					Difficulty concentrating when people are speaking to you?
					Misplace or have difficulty finding things?
					Are you easily distracted by activity or noise around you?
					Leave your seat/ move when expected to remain seated/ stay still?
					Feel restless or fidgety?
					Have difficulty unwinding / relaxing when you have the time?
					Find yourself talking too much when you are in social situations?
					Find yourself finishing others sentences while they still are talking?
					Have difficulty waiting your turn when turn taking is required?
					Interrupt others when they are busy?

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Stressors

How much stress is each category currently causing you?

None	Mild	Moderate	Severe	
				Family
				Friends
				Relationships (non – romantic/ casual)
				Educational
				Economic/ Financial
				Occupational (work)
				Housing
				Legal
				Health (Medical/ Mental)

Physical Review of Systems

Are you experiencing any physical symptoms in any of the following categories? If so, please <u>briefly</u> specify

None (Please check if no problems)	
Eye/Vision	
Ears/Nose/Mouth/Throat	
Cardiovascular (heart)	
Respiratory (lungs)	
Musculoskeletal (muscles/bones)	
Gastrointestinal (stomach)	
Endocrine (Hormones/thyroid)	
Lymphatic/Hematologic (blood)	
Urinary/ Reproductive	
Neurological(head – non psyche)	
Integumentary (Skin/Hair)	

Are you experiencing any of the following psychiatric symptoms:

Yes	No		Yes	No	
		Feeling depressed			Stress
		Difficulty Concentrating			Disturbing thoughts
		Phobias/unexplained fears			Manic episodes
		No pleasure from life anymore			Confusion
		Anxiety			Memory Loss
		Insomnia			Nightmares
		Excessive moodiness			Other

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Substance Abuse History

Do you have a history of any <u>recreational</u> drug use/abuse?
Do <u>NOT</u> check below if you have taken these <u>prescribed</u>

Yes	No

Yes	No	Substance	How was it used? Oral/ edible - Nasal - Inhaled/smoked - Injected	Age(s) of use
		Amphetamines/Speed		
		Barbiturates/ Downers		
		Opiates		
		Cocaine		
		Psychedelics		
		Inhalants		
		Cannabis/ Marijuana		
		Benzodiazepines		
		PCP		

Have you received any treatment for substance abuse?

Yes	No	Treatment Type	Length of treatment	Age of treatment
		Inpatient		
		Intensive Outpatient		
		Outpatient		
		12 Step Program		
		Other		

Have you experienced any of these consequences as a result of alcohol consumption <u>or</u> abuse of substances?

Yes	No		Yes	No	
		Felt that you needed to cut down on alcohol consumption/drinking			Using/ consuming more than intended
		Been annoyed by others criticizing your drinking			Unintentional overdose
		Felt guilty about drinking			DUI
		Needing a drink first thing in the morning			Arrests
		Increased tolerance (alcohol or other substance)			Physical fights or assaults
		Withdrawal effects (shakes, sweating, nausea, rapid heart rate)			Relationship conflicts
		Seizures			Problems with money
		Blackouts			Job loss or problems at work/school
		Effects on physical health			Other, please specify:

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History of Psychiatric Treatment

Do you have any history of <u>inpatient</u> psychiatric treatment?
(Hospitalized for more than a few hours/spent the night in a hospital/facility**)**

Yes	No

<u>First Hospitalization</u>
Name of Hospital/ Facility: _____

Reason for hospitalization: ____ Depression ____ Suicidal Thoughts ____ Suicidal Attempt
____ Manic Episode ____ Psychotic Episode ____ Severe Anxiety ____ Drug/Alcohol Related
____ Assault ____ Violence ____ Other: _____

Age of Hospitalization: _____ **Was it voluntary? _____**

Outcome of Stay: ____ Resolved or nearly resolved Problem _____ Significant Improvement
____ Partial Response ____ Minor Improvement/No Effect _____ Feeling worse or negative result

<u>Second Hospitalization: (Leave blank if only had 1 event)</u>
Name of Hospital/ Facility: _____

Reason for hospitalization: ____ Depression ____ Suicidal Thoughts ____ Suicidal Attempt
____ Manic Episode ____ Psychotic Episode ____ Severe Anxiety ____ Drug/Alcohol Related
____ Assault ____ Violence ____ Other: _____

Age of Hospitalization: _____ **Was it voluntary? _____**

Outcome of Stay: ____ Resolved or nearly resolved Problem _____ Significant Improvement
____ Partial Response ____ Minor Improvement/No Effect _____ Feeling worse or negative result

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Do you have a history of <u>outpatient</u> psychiatric treatment?

(Seen a provider for mental health symptoms & prescribed psychiatric medication)
If No, skip to next section

Yes	No

1. **Name of Provider**/Office/Clinic: _____
   Age at start of treatment: ____

Reason for seeking Treatment: ____ Depression ____Panic ____Anxiety ____ Social Anxiety
_____ Obsessive Compulsive ____ PTSD ____ Bipolar ____ Eating Disorder
_____ Alcoholism ____ Drug Abuse ____ ADHD ____ Personality Disorder
_____ Schizophrenia/Psychosis ____ Autism Spectrum ____ Disruptive Behavior
_____ Other: _____

Response to treatment: ____ Resolved/Nearly resolved Problem ____ Significant Improvement
____ Partial Response ____ Minor Improvement/No Effect _____ Feeling worse or negative result

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(Outpatient Psychiatric treatment info continued)

2. **Name of Provider**/Office/Clinic seen: _____
   Age at start of treatment: ____

Reason for seeking Treatment: ____ Depression ____Panic ____Anxiety ____ Social Anxiety
_____ Obsessive Compulsive ____ PTSD ____ Bipolar ____ Eating Disorder
_____ Alcoholism ____ Drug Abuse ____ ADHD ____ Personality Disorder
_____ Schizophrenia/Psychosis ____ Autism Spectrum ____ Disruptive Behavior
_____ Other: _____

Response to treatment: ____ Resolved/Nearly resolved Problem ____ Significant Improvement
____ Partial Response ____ Minor Improvement/No Effect _____ Feeling worse or negative result

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Suicide/ Self Harm History

Have you ever tried to harm or kill yourself? ____ Yes ____ No (If no, Skip to next section)
If yes, was your intent to die? ---------- ____ Yes ____ No
How many times in your life has this occurred? _____

Episode 1 Month/Year _____
Method: ____ Overdose ____ cutting ____ Gunshot ____ Drowning_
____ Hanging ____ Jumping from height ____ Vehicle ____ Carbon Monoxide
____ Suffocation

Consequences: ____ No medical treatment ____ Outpatient medical visit ____ Emergency room
____ hospital admission (inpatient) ____ Intensive Care Unit (ICU)

Episode 2 Month/Year _____
Method: ____ Overdose ____ cutting ____ Gunshot ____ Drowning_
____ Hanging ____ Jumping from height ____ Vehicle ____ Carbon Monoxide
____ Suffocation

Consequences: ____ No medical treatment ____ Outpatient medical visit ____ Emergency room
____ hospital admission (inpatient) ____ Intensive Care Unit (ICU)

Violence History

Have you had any history of violent behavior?

Yes	No

If yes, please specify:

_____

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Past Medical History

Who is your primary care/family physician?

_____

Are you currently taking any NON – Psych Medication? If yes, please specify names:

_____

_____

Do you have a history of any of the following health problems? Check all that apply

	Allergies		Glaucoma		Kidney Stones
	Anemia		Gout		Liver Disease
	Arthritis		High Cholesterol		Lupus
	Asthma		Hearing Loss		Migraine Headaches
	Back/ Spine problems		Heart Disease		Multiple Sclerosis
	Cancer		Heart Defect		Obesity/Overweight
	Cataracts		Heart Valve problems		Parkinson's Disease
	Chickenpox		Hemorrhoids		Polyps
	Chronic Bronchitis		Hepatitis		Seizures
	COPD/Emphysema		Hernia		Sexually Transmitted Infections/ STD's
	Diabetes		HIV		Sleep Apnea
	Diverticulitis		High Blood Pressure		Stroke/ TIA
	Fainting spells/passing out		Low Blood Pressure		Low Testosterone
	Fibromyalgia		IBS/ Inflammatory Bowel Disease		Thyroid Problems
	Gall Bladder Disease		Iron Deficiency		Tuberculosis/ exposure to TB
	Gastritis/Ulcer		Kidney Disease		Other: _____

Have you had any surgery in any of the following areas? Check all that apply

	Back/Neck		Hysterectomy (ovaries removed)		Prostate
	Brain		Intestine		Sex Change
	Cardiac		Kidney		Shoulder/Elbow/Wrist/Hand
	Ear/Nose/Throat		Liver		Stomach
	Gall Bladder		Lung		Tonsils
	Hernia		Pancreas		Vagina
	Hip/Knee/Ankle/Foot		Pelvis		Weight Loss
	Hysterectomy (ovaries retained)		Penis		Other: _____

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Have you ever taken any of the following Psychiatric Medication? Yes No

	Abilify(aripiprazole)		Invega (paliperidone)		Revia (naltrexone)
	Adderall		Keppra (Levetiracetam)		Risperdal (risperidone)
	Ambien (zolpidem)		Klonopin (Clonazepam)		Ritalin (methylphenidate)
	Anafranil/clomipramine		Lamictal (Lamotrigine)		Rozerem (ramelteon)
	Antabuse (disulfiram)		Latuda		Seroquel (quetiapine)
	Ativan (lorazepam)		Lexapro (escitalopram)		Serzone (nefazidone)
	Buspar (Buspirone)		Librium		Sinequan (doxepin)
	Campral (acamprosate)		Lithobid		Sonata (zaleplon)
	Catapres (clonidine)		Lithium		Stelazine (trifluoperazine)
	Celexa (citalopram)		Lunesta (Eszopiclone)		Strattera (atomoxetine)
	Clozaril (Clozapine)		Luvox (fluvoxamine)		Suboxone (buprenorphine)
	Concerta		Lyrica (pregabalin)		Subutex (buprenorphine)
	Contrave		Melatonin		Tegretol (carbamazepine)
	Cymbalta (duloxetine)		Mellaril (thioridazine)		Tenex (guanfacine)
	Cytomel		Methadone		Thorazine (chlorpromazine)
	Depakote (Divalproex)		Navane (thiothixene hcl)		Topamax (topiramate)
	Dexedrine		Neurontin (gabapentin)		Trazodone (Desyrel)
	Doxepin (sinequan)		Orap (pimozide)		Trileptal (oxcarbazepine)
	Effexor (Venlafaxine)		Pamelor (nortriptyline)		Valium (diazepam)
	Elavil (amitriptyline)		Paxil (paroxetine)		Viibryd (vilazodone)
	Fanapt (iloperidone)		Phentermine		Vistaril (hydroxyzine)
	Fiornal		Pristiq (desvenlafaxine)		Vyvanse
	Focalin		Propranolol		Wellbutrin (bupropion)
	Gabitril		Provigil (modafinil)		Xanax (alprazolam)
	Geodon (ziprasidone)		Prozac (fluoxetine)		Zoloft (sertraline)
	Haldol (haloperidol)		Remeron (mirtazapine)		Zyprexa (olanzapine)
	Intuniv		Restoril (temazepam)		

If you have ever had any **side effects** to any psych medication, please specify what medication & the side effect(s) you experienced or the reason why you stopped any psych medication for any other reasons:

_____

_____

_____

Are you allergic to any medications or other substances? Yes No

Yes, Specify what it is, & what reaction you had: _____

_____

_____

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Family History

Do you have any family members with a history of **mental health issues**? If yes, Please elaborate what problems they had (ex: Mom – depression) _____
_____

Do you have any family members with a history of any medical problems? _____
_____

Developmental & Educational History

When <u>your mother</u> was pregnant with <u>you</u>, did she have any of the following problems? ____ No problems
____ Exposure to drugs/alcohol during pregnancy ____ A difficult pregnancy
____ Problems with delivery ____ Other:_____

Did you have any complications after your birth?
____ Premature ____ Jaundice ____ breathing difficulties ____ None

Did you have any delays /difficulties in reaching the following milestones?
____ Walking ____ Talking ____ Toilet Training ____ Sleeping Alone
____ Being away from parents ____ Making Friends Other: _____

How would you best describe your childhood home atmosphere?
___ Normal ___ Supportive ___ Parental fighting ___ Parental Violence
___ Financial difficulties ___ Frequent Moving ___ Other: _____

Did you experience any of the following challenges during your <u>childhood?</u> ____ None
____Tantrums ____ Bed wetting ____ Running away from home ____ Fighting
____Stealing ____ Property damage ____ Fire Setting ____ Animal cruelty
____ Separation anxiety ____ Victim of bullying ____ Engaged in bullying ____ Depression
____ Death of a parent ____ Parental Divorce

Did you have any of the following problems in school? ____ None
____ Fighting ____ School phobia ____ Truancy ____ Detentions
____ Suspensions ____ Expulsions ____ School refusal ____ Class failures
____ Repetition of grades ____ Special education ____ Remedial classes

Did you have any additional schooling outside of the standard classroom setting?
____ Speech classes ____ Tutoring ____ Accommodations ____ Other: _____

What is your highest level of education:
____ Less than High School ____ High School/GED ____ Some College
____ 2 year degree ____ 4 year degree ____ Graduate/professional degree

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General Social History

How would you best describe your social situation?
____ Supportive social network ____ Few friends ____ Substance use base friends
____ No friends ____ Distant from family of origin ____ Family conflict
____ Other: _____

What is your current marital status? ____ single, never married ____ Married/ permanent partnership
____ Divorced ____ Separated/divorce in process ____ Widowed

What is the status of your intimate relationship?
____ Never been in a serious relationship
____ Not currently in a serious relationship
____ Currently in a serious relationship

What is the satisfaction level of your intimate relationship?
____ Not Applicable ____ Very Satisfied ____ Satisfied ____ Somewhat Satisfied ____ Dissatisfied

What is your sexual orientation? ____ Heterosexual ____ Homosexual ____ Bisexual

What is your current living situation?
____ Rent _____ Own _____ Group home _____ Foster care _____ Homeless

Who do you live with? ____ Live Alone ____ Roommates ____ Partner/spouse ____ Parent(s)
____ Siblings ____ Children ____ Other: _____

Do you currently participate in spiritual activities? _____ Yes _____ No

What is your occupation status?
____ Employed full time ____ Employed part time ____ Temp/seasonal ____ Retired
____ Full Time Student ____ Part time student ____ Homemaker ____ Disability
____ Unemployed (seeking work) ____ Unemployed (Not seeking work)

What is your currently yearly income?
____ Less than 11k ____ 11k – 25k ____ 26k – 75k ____ 76k – 100k ____ More than 100k

What is your longest period of continuous employment? _____

What is your longest period of unemployment? _____

For Females Only ~ Menstruation & Pregnancy History

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For Females Only ~ Menstruation & Pregnancy History

At what age did you begin menstruation? _____

Which of these best describe your current premenstrual symptoms?

___ Dysphoria (state of unease) ___ Cramps ___ Appetite Change
___ Bloating ___ Sleep Disturbance ___ None of these

Do you have a method of contraception (birth control)? ___ None

___ Intrauterine (IUD) ___ Hormonal (implant, injection, patch, pill, ring)
___ Barrier (condom, spermicide) ___ Fertility Awareness based
___ Permanent (sterilization, infertility) ___ Other: _____

Have you ever been pregnant? Yes No - How many times? ___

If you HAVE been pregnant, **have you given birth?** Yes No - How many times? ___

If you have NOT given birth, **have you had any miscarriages?** Yes No - How many times? ___

If you have NOT given birth, **have you had any abortions?** Yes No - How many times? ___