

New Patient Questionnaire

To help us to fully evaluate your concerns, please fill out the following intake form and questionnaire to the best of your ability. We realize that there is a lot of information requested, and you may not remember or have access to all of it, but please be as thorough as possible.

PATIENT IDENTIFICATION:

Name _____ Age _____ Sex _____
Birth Date _____ Marital Status _____
Address _____
City _____ State _____ Zip _____ - _____
Home Phone (____) ____ - _____ Work Phone (____) ____ - _____ Cell Phone (____) ____ - _____
Who do you currently live with? _____

REFERRAL SOURCE:

Name _____ Phone ____ / ____ - _____ Fax ____ / ____ - _____
Address _____

MAIN PURPOSE FOR THE CONSULTATION [please give a summary of the main problem(s)]

WHY DID YOU SEEK THE EVALUATION AT THIS TIME? (What are your goals for this visit?)

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MENTAL HEALTH HISTORY/PRIOR MENTAL HEALTH TREATMENTS (include any history of counseling/therapy as well as prior psychiatric care)

PRIOR MEDICATIONS PRESCRIBED FOR MENTAL HEALTH REASONS (for depression, anxiety, mood stability or sleep)

MEDICAL HISTORY:

Current medical problems and/or medications:

Current Supplements/vitamins/herbs:

Past medical problems/medications:

Other doctors/clinics seen regularly:

Any history of head trauma? (describe)

Any history of seizures or seizure-like activity?

Prior hospitalizations:

Prior abnormal lab tests/values?

Allergies/ drug intolerance?

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CURRENT LIFE STRESSES: (include anything that is currently stressful for you, such as relationships, job, school, finances, children)

YOUR PRENATAL AND BIRTH EVENTS: (Pregnancy complication, birth trauma, bleeding, medication, smoking, alcohol/drugs)

SLEEP BEHAVIOR: (trouble getting to sleep, trouble staying asleep, excessive snoring, sleepwalking, nightmares, recurrent dreams, excessive daytime sleepiness)

SCHOOL HISTORY: Last grade completed ____ Last school attended _____

Average grades received _____ Specific learning disabilities _____

Any behavior problems in school?

What have teachers said about your learning and behavior in school?

EMPLOYMENT HISTORY: (summarize the jobs you have held; most favorite, least favorite)

Any work-related problems?

What have your employers and supervisors said about your performance?

MILITARY HISTORY: _____

LEGAL PROBLEMS/DIFFICULTY WITH THE LAW:

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ALCOHOL AND DRUG HISTORY: Please list the age you started, types of substances used through the years and any current usage. Also, describe how each of these substances made you feel; what benefit you got from them. This question includes alcohol (hard liquor, beer, wine), marijuana or hash, prescription tranquilizers or sleeping pills, inhalants, (glue, gasoline, cleaning fluids, etc.), cocaine or crack, amphetamines or crank or ice, steroids, opiates (heroin, codeine, morphine or other pain killers) barbiturates, hallucinogenic drugs (LSD, mescaline, mushrooms), PCP:

Did you ever experience withdrawal symptoms from alcohol or drugs? _____

Has anyone ever told you they thought you had a problem with drugs or alcohol? _____

Have you felt guilty about your drug or alcohol use? _____

Have you felt annoyed when someone talked to you about your use of drugs/alcohol? _____

Have you ever used alcohol or drugs first thing in the morning? _____

Caffeine use per day (coffee, tea, sodas, chocolate) _____

Nicotine use per day, past and present (cigarettes, cigars, chewing tobacco) _____

SEXUAL HISTORY: (answer if comfortable)

Age at time of first sexual experience _____ Number of sex partners _____

History of sexually transmitted diseases _____ History of abortion _____

History of sexual molestation, abuse or rape _____

Current sexual problems?

FAMILY HISTORY:

Family structure (Who lives in your current household? Please give relationship to each)

Current marital or relationship satisfaction:

Significant events (include marriages, divorces, separations, deaths, traumatic events)

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NATURAL MOTHER'S HISTORY: Age _____ Outside work _____

School-highest grade completed _____ Learning Problems _____

Behavioral Problems _____ Marriages _____

Medical Problems _____

Has mother or any maternal relatives had any learning problems or mental health problems including alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalization, physical or sexual abuse? If yes, please describe

NATURAL FATHER'S HISTORY: Age _____ Outside work _____

School-highest grade completed _____ Learning Problems _____

Behavioral Problems _____ Marriages _____

Medical Problems _____

Has father or any paternal relatives had any learning problems or mental health problems including alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalization, physical or sexual abuse? If yes, please describe

SIBLINGS: (names, ages, problems, strengths, relations with patient)

CHILDREN: (names, ages, problems, strengths, relations with patient)

CULTURAL /ETHNIC BACKGROUND:

DESCRIBE YOUR RELATIONSHIP WITH FRIENDS:

DESCRIBE YOURSELF/ YOUR STRENGTHS:

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GENERAL SYMPTOM CHECKLIST

Please rate yourself on each of the symptoms below using the following scale. If possible, to give us the most complete picture, have another person who knows you well (spouse, lover, or parent) rate you as well. List other person _____

0	1	2	3	4	N/A
Never	Rarely	Occasionally	Frequently	Very Frequently	Not applicable

Other | Self

- ___ | ___ 1. Depressed, sad, down or blue mood
- ___ | ___ 2. Decreased interest in things that are usually enjoyable, including sex
- ___ | ___ 3. Significant weight gain or loss, or marked appetite changes
- ___ | ___ 4. Recurrent thoughts of death or suicide
- ___ | ___ 5. Sleep changes, lack of sleep or marked increase in sleep
- ___ | ___ 6. Physically agitated OR feeling slowed down physically
- ___ | ___ 7. Low energy or feelings of tiredness
- ___ | ___ 8. Feelings of worthlessness, helplessness, hopelessness, or guilt
- ___ | ___ 9. Decreased concentration or memory
- ___ | ___ 10. Periods of an elevated, high or irritable mood
- ___ | ___ 11. Periods of a very high self-esteem, or grandiose thinking
- ___ | ___ 12. Periods of decreased need for sleep (or not being able to sleep) without feeling tired
- ___ | ___ 13. More talkative than usual or feel pressure to keep talking
- ___ | ___ 14. Racing thoughts; frequent jumps from one subject to another
- ___ | ___ 15. Easily distracted by irrelevant or low priority things
- ___ | ___ 16. Marked increases in activity level
- ___ | ___ 17. Excessive involvement in pleasurable activities which have the potential for painful consequences (spending money, sexual indiscretions, gambling, foolish business ventures)
- ___ | ___ 18. Panic attacks, which are period of intense, unexpected fear or emotional discomfort (list number per month ___)
- ___ | ___ 19. Periods of trouble breathing or feeling smothered
- ___ | ___ 20. Periods of feeling dizzy, faint, or unsteady on your feet
- ___ | ___ 21. Periods of heart pounding or rapid heart rate
- ___ | ___ 22. Periods of trembling or shaking
- ___ | ___ 23. Periods of sweating
- ___ | ___ 24. Periods of choking
- ___ | ___ 25. Periods of nausea or abdominal upset
- ___ | ___ 26. Feeling of a situation "not being real" or feeling that you are disconnected from your body
- ___ | ___ 27. Numbness or tingling sensation
- ___ | ___ 28. Hot or cold flashes
- ___ | ___ 29. Periods of chest pain or discomfort

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0	1	2	3	4	N/A
Never	Rarely	Occasionally	Frequently	Very Frequently	Not applicable

Other| Self

- ___ |___ 30. Fear of dying
- ___ |___ 31. Fear of going crazy or doing something uncontrolled
- ___ |___ 32. Avoiding everyday places for fear of having a panic attack, or need to go with other people in order to feel comfortable
- ___ |___ 33. Excessive fear of being judged by others, which causes you to avoid or get anxious in situations
- ___ |___ 34. Persistent, excessive phobias (heights, closed spaces, specific animals, etc.) Please list _____
- ___ |___ 35. Recurrent, bothersome thoughts, ideas, images, which you try to ignore
- ___ |___ 36. Trouble getting “stuck” on certain thoughts, or having the same thought over and over
- ___ |___ 37. Excessive or senseless worrying
- ___ |___ 38. Others complain that you worry too much or get “stuck” on the same thoughts
- ___ |___ 39. Compulsive behaviors that you must do over and over or else you feel anxious (i.e., handwashing, checking locks), or compulsive spelling or counting
- ___ |___ 40. Needing to have things done a certain way or you become upset
- ___ |___ 41. Others complain that you do the same thing over and over to an excessive degree (cleaning, checking)
- ___ |___ 42. Recurrent and upsetting thoughts of a past traumatic event (molestation, accident, fire, etc)
- ___ |___ 43. Recurrent distressing dreams of a past upsetting event
- ___ |___ 44. A sense of reliving a past upsetting event
- ___ |___ 45. A sense of panic or fear to events that resemble an upsetting past event
- ___ |___ 46. You spend effort avoiding thoughts or feelings associated with a past trauma
- ___ |___ 47. Persistent avoidance of activities/situations which cause remembrance of upsetting events
- ___ |___ 48. Inability to recall an important aspect of a past upsetting event
- ___ |___ 49. Marked decreased interest in important activities
- ___ |___ 50. Feeling detached or distant from others
- ___ |___ 51. Feeling numb or restricted in your feelings
- ___ |___ 52. Feeling that your future is shortened
- ___ |___ 53. Startling easily
- ___ |___ 54. Feel like you are always watching for bad things to happen
- ___ |___ 55. Marked physical response to events that remind you of a past upsetting event (i.e., sweating when getting in a car long after you have been in an accident)
- ___ |___ 56. Marked irritability or angry outbursts
- ___ |___ 57. Unrealistic or excessive worry in at least a couple of areas in your life.

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0	1	2	3	4	N/A
Never	Rarely	Occasionally	Frequently	Very Frequently	Not applicable

Other| Self

- ___|___ 58. Trembling, twitching or feeling shaky
- ___|___ 59. Muscle tension, aches or soreness
- ___|___ 60. Easily fatigued
- ___|___ 61. Feelings of restlessness
- ___|___ 62. Shortness of breath or feeling smothered
- ___|___ 63. Heart disease, cardiovascular symptoms, high blood pressure, exercise intolerant
- ___|___ 64. Sweating or cold clammy hands
- ___|___ 65. Dry mouth
- ___|___ 66. Dizziness or lightheadedness
- ___|___ 67. Nausea, diarrhea. or other abdominal distress
- ___|___ 68. Hot or cold flashes
- ___|___ 69. Frequent urination
- ___|___ 70. Trouble swallowing or “lump in throat”
- ___|___ 71. Feeling keyed up or on edge
- ___|___ 72. Quick startle response or jumpy feeling
- ___|___ 73. Difficulty concentrating or “mind going blank”
- ___|___ 74. Trouble falling asleep or staying asleep
- ___|___ 75. Irritability
- ___|___ 76. Trouble sustaining attention or being easily distracted
- ___|___ 77. Difficulty completing projects
- ___|___ 78. Feeling overwhelmed with the tasks of everyday life
- ___|___ 79. Trouble maintaining an organized work area or living area
- ___|___ 80. Inconsistent work performance
- ___|___ 81. Lack of attention to detail
- ___|___ 82. Make decisions impulsively
- ___|___ 83. Difficulty delaying what you want, having to have your needs met immediately
- ___|___ 84. Restless or fidgety
- ___|___ 85. Make comments to others without considering their impact
- ___|___ 86. Impatient, easily frustrated
- ___|___ 87. Frequent traffic violations or frequent near accidents
- ___|___ 88. Refusal to maintain body weight above a level most people consider healthy
- ___|___ 89. Intense fear of gaining weight or becoming fat even though underweight
- ___|___ 90. Feelings of being fat, even though you are underweight

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0 1 2 3 4 N/A
Never Rarely Occasionally Frequently Very Frequently Not applicable

Other|Self

- ___ ___ 91. Recurrent episodes of binge eating
- ___ ___ 92. Feeling of lack of control over eating behavior
- ___ ___ 93. Persistent overconcern with body shape or weight
- ___ ___ 94. Engage in regular activities to end binges such as self-induced vomiting, laxatives, diuretics, dieting or strenuous exercise
- ___ ___ 95. Involuntary movements (tics) or vocal tics
- ___ ___ 96. Delusional or bizarre thoughts (that you know others would think are false)
- ___ ___ 97. Seeing objects, shadows or movements that are not real
- ___ ___ 98. Hearing voices or sounds that are not real
- ___ ___ 99. Periods of time where your thoughts or speech were disjointed or did not make sense to you or others
- ___ ___ 100. Social isolation or withdrawal
- ___ ___ 101. Severely impaired ability to function at home or work or socially
- ___ ___ 102. Peculiar behaviors
- ___ ___ 103. Lack of personal hygiene or grooming
- ___ ___ 104. Marked lack of initiative
- ___ ___ 105. Inappropriate mood for the situation (laughing at sad events)
- ___ ___ 106. Frequent feeling that someone or something is out to hurt you or discredit you
- ___ ___ 107. Do others complain that you snore loudly?
- ___ ___ 108. Have others said you stop breathing when you sleep?
- ___ ___ 109. Do you feel fatigued or tired during the day?
- ___ ___ 110. Do you often feel cold when others feel fine or warm?
- ___ ___ 111. Do you often feel warm when others feel fine or cool?
- ___ ___ 112. Do you have problems with brittle or dry hair?
- ___ ___ 113. Do you have problems with dry skin?
- ___ ___ 114. Do you have problems with sweating?