TrueCare Behavioral Health Center, Inc.

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NEW PATIENT QUESTIONNAIRE

Please fill out the following confidential intake form prior to your first appointment with our staff psychiatrist. By answering these questions accurately and thoughtfully, you will be helping set the therapeutic process in motion. If you are uncomfortable answering any of these questions, please feel free to leave them blank; we can discuss them in more detail at your initial evaluation.

PATIENT IDENTIFICATION:

Name:____ Date: ____________________

Birthdate: ___________________ Age: ________ SSN#: ____________________

Marital Status: ________________ Occupation: _______________________________

Email Address: ___________________________ Preferred Phone Number: (_____)___________

Street Address: ____

City/State/Zip code: ____

How did you hear about TrueCare Behavioral Health Center, Inc.: ________________________

Please list Emergency Contacts:

Name:____Phone: (______)_______________

Name:____Phone: (______)_______________

PURPOSE OF CONSULTATION: (Please describe your reasons for seeking treatment at this time):

____

____

PRESENTING SYMPTOMS: Please check any symptoms that may pertain to you:

□ Depressed or sad mood
□ Difficulty enjoying usual activities
□ Unintentional weight loss or weight gain
□ Sleeping too much or not enough
□ Feeling agitated or sluggish
□ Lacking energy/always tired
□ Feeling guilty or worthless
□ Poor focus and concentration
□ Thoughts of death or suicide
□ Inflated self-esteem
□ Decreased need for sleep or going for days without sleeping
□ Excessive talking
□ Racing thoughts
□ Feeling highly distractible
□ Try to do or accomplish way too much in a day
□ Impulsive behavior
□ Seeing or hearing things that may not be real
□ Feeling like people are watching you or out to get you
□ Often tense or unable to relax
□ Excessive worrying
□ Panic Attacks
□ Extreme unreasonable fears
□ Afraid/unable to leave home
□ Intense fear of social situations
□ Cannot prevent repetitive thoughts
□ Cannot prevent repetitive behaviors
□ Intrusive, upsetting memories of past events
□ Always on guard or never feel safe
□ Body overreacts to “stress”

LIFE PROBLEMS THAT CURRENTLY AFFECT YOU:

□ Problems within my family
□ Problems among my friends/community
□ Educational problems
□ Occupational/Job problems
□ Housing problems
□ Financial/Economic problems
□ Problems with the law, legal system
□ Destructive/violent thoughts or behaviors
□ Attempts to hurt, harm, or mutilate self
□ Anger outbursts
□ Discipline problems at work
□ Careless, high risk behavior

PAST PSYCHIATRIC HISTORY:

Have you ever been hospitalized for psychiatric reasons? YES __ NO __. If yes, please elaborate: ____
____
____

Have you ever seen a psychiatrist on an outpatient basis? YES __ NO __. If yes, please give details: ____
____
____

Have you ever received counseling or psychotherapy in the past? YES __ NO __. If yes, please elaborate: ____
____
____
____

Which psychiatric medications have you taken in the past and what were the benefits and/or side effects you experienced? ____
____
____
____

Are you currently taking any psychiatric medications? YES __ NO __ . If yes, please list all current medications along with dosages and prescribing physician name: __________________
____
____
____

GENERAL MEDICAL HISTORY:

Do you have a Primary Care Physician (PCP)? YES __ NO __ . If yes, please list name of PCP and his or her phone # and address: ____

____

____

Date of Last Physical Exam: _______________ Date of Last Lab Work up: ________________

Are you pregnant? Yes ____ No ____ N/A ____ Last menstrual Period: _________________

Do you suffer from any of the following general medical problems? Please check all that apply:

□ Chest Pain	□ Glaucoma	□ Emphysema
□ Diabetes	□ Visual Spots	□ Chronic Cough
□ Thyroid Disease	□ Double Vision	□ Bronchitis
□ Hormone Problems	□ Hearing Problems	□ Pneumonia
□ Fever or Sweats	□ Speaking Problems	□ Tuberculosis
□ Blood Disease	□ Memory Problems	□ Skin Ulcer/Lesion
□ Anemia	□ Early Fatigue	□ Seizures
□ Bruise Easily	□ Daytime Sleepiness	□ Fainting
□ Nose Bleed	□ Difficulty Sleeping	□ Vertigo/Dizziness
□ Liver Disease	□ Concentration Problems	□ Motor Difficulties
□ Jaundice	□ Sinus or Nasal Problems	□ Serious Head Injury
□ Hepatitis	□ Heart Attack	□ Recurring Headaches
□ Stomach Ulcers	□ Coronary Artery Disease	□ Arthritis
□ Nausea/Vomiting	□ Rheumatic Fever	□ Muscle Cramps
□ Unusual Diet	□ High Blood Pressure	□ Muscle Stiffness
□ Abdominal Pain	□ High Blood Pressure	□ Weakness
□ Skin Rash	□ Stroke	□ Tremors
□ Neurological Disorder	□ Heart Palpitations	□ Numbness
□ Sexually Transmitted Disease	□ Heart Surgery	□ Difficulty Walking
□ HIV	□ Pace Maker Implant	□ Uncontrolled movements
□ Sexual Difficulties	□ Cancer	□ Recurrent Infection of any kind
□ Gynecological Problems	□ Lung Disease	□ Depressed Immune System
□ Prostate Problems	□ Asthma	

Do you take any prescription medications for your general medical problems? YES __ NO __. If yes, please list: ____

____

____

Do you take over-the-counter medications, herbal or dietary supplements, or vitamins? YES __ NO __. If yes, please list: ____

____

____

Are you allergic to any medications? YES __ NO __. If yes, please list medications and allergic reactions: ____

____

____

Have you undergone any surgical procedures? YES __ NO __. If yes, please list all surgical procedures: ____

____

Do you have any problems with chronic physical pain or fibromyalgia? YES __ NO __ . If yes, please describe and rate your average pain level using the scale below: ______________________

____

Circle one 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
(no pain) (worst pain)

Have you ever suffered a severe head injury with loss of consciousness or a concussion? YES __ NO __ . If yes, please describe: ____

____

<u>ALCOHOL, DRUG AND TOBACCO USE:</u>

ALCOHOL: Would you say you are a non-drinker? are a social drinker? are a regular drinker? have a drinking problem? are an alcoholic?
Regardless of the box you checked, please describe the frequency of your alcohol use and what kind of alcohol and how much you drink, including date of last use: ______________________

____

____

____

Have you had any problems related to use or undergone treatment for use? YES __ NO __ . If yes, please describe (Legal, Financial, Health, or Relationship problems): ___________________

____

____

____

DRUG AND/OR PRESCRIPTION DRUG USE: Check if none ____ .

Would you say you ❑ are a recreational drug user? ❑ have a drug problem? ❑ have a drug addiction?

Please check which substances below you regularly use:

□ Benzodiazepines (Klonopin, Valium, Xanax, Ativan)
□ Caffeine
□ Marijuana/THC
□ Cocaine/Crack
□ Designer Drugs (such as Club Drugs: G, X)
□ Hallucinogens (LSD, Mushrooms)
□ Inhalants (Gasoline, Glue, Aerosol)
□ Methamphetamines (Speed, Ice, Adderall)
□ Opiates/Methadone (Vicodin, Oxycontin, Heroin)
□ Prescription Pills (please list): ____
____
□ Tobacco

Which of these have you experienced related to your drug use?
❑ Blackouts
❑ Bad reactions
❑ Withdrawal symptoms
❑ Cravings
❑ Overdoses
❑ Tolerance ("Could not get high no matter how much I used")
❑ Preoccupation (Spent lots of time finding and using substance)
❑ Failed attempts to cut down or control use
❑ Detoxification in a hospital
❑ Other problems: ____

SOCIAL HISTORY:

Where were you born and where did you grow up? ___________________________________
____

Did your parents stay together while you were growing up? YES __ NO __ . If no, how old were you when they separated? ___________________________

Father's occupation while you were growing up: ___________________________________

Mother's occupation while you were growing up: ___________________________________

How would you describe your current relationship with your father? Good __ Average __ Bad __

How would you describe your current relationship with your mother? Good __ Average __ Bad _

How many siblings do you have? None _____ Brothers ______ Sisters______

How would you describe your relationship with your siblings? Good __ Average __ Bad __ and describe: ____

Were there any complications at your birth (premature birth, major medical problems)?
YES __ NO __. If yes, please describe: ____

Any problems in your early development (learning to walk, talk, read, etc)? YES __ NO __ .
If yes, please describe: ____

Did you suffer from any major illnesses / injuries while you were growing up? YES __ NO __ .
If yes, please describe: ____

Are you/were you a victim of any form of abuse? Please describe below if you feel comfortable sharing:

Physical Abuse: YES __ NO __. If yes, please describe and specify age of occurrence:

____

Sexual Abuse: YES __ NO __. If yes, please describe and specify age of occurrence:

____

Emotional/Verbal Abuse: YES __ NO __. If yes, please describe and specify age of occurrence: ____

____

What is the highest educational degree you have obtained? ______________________________

____

What kinds of jobs and/or professions have you had in the past? __________________________

____

____

Are you currently employed? Yes __ No __. If yes, where? ______________________________

____

Are you currently involved in a romantic relationship? YES __ NO __ . If yes, what is your partner's first name and occupation? ____

How long have you been together? ____

How would you describe your relationship? ____

Have you been involved in any previous significant intimate/romantic relationships?
YES __ NO __ . If yes, please describe briefly: ____
____
____

Do you have any children? YES __ NO __ . If yes, what are their names & ages? ___________
____
____

What are some things you enjoy doing in your spare time? (hobbies, interests, etc)? __________
____
____

Have you ever been convicted of any crimes, incarcerated in prison, or placed on probation?
YES __ NO __ . If yes, please describe: ____
____

FAMILY HISTORY:

Is there any family history of mental illness or substance abuse among your blood relatives?
YES __ NO __ . If yes, please describe as below:

Father's Side: ____
____
____

Mother's Side: ____
____
____

RISK ASSESSMENT:

Do you have thoughts of harming yourself? YES __ NO __

Do you have a plan for how you would harm yourself? YES __ NO __

Have you attempted to harm yourself in the past? YES __ NO__

Have any relatives who committed suicide? YES __ NO __

Do you have thoughts of harming someone else? YES __ NO __

Have you assaulted or threatened anyone recently? YES __ NO ___

Have you ever been in trouble because of your temper/violence? YES __ NO __

Does drinking/drugging ever lead you to become violent? YES __ NO __

Do you own a gun or a lethal weapon? YES __ NO __

Have you ever considered/planned harming yourself or others with this gun or other lethal weapon? YES __ NO __

ADDITIONAL INFORMATION YOU WOULD LIKE DR. ABAD-SANTOS TO KNOW:

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____

____

____

____

Thank you for taking the time to fill out this confidential form accurately and thoughtfully.

____ ____________________

Patient's Signature Date