New Patient Questionnaire

NAME	DATE OF BIRTH	TODAY'S DATE

PLEASE LIST MEDICAL PROBLEMS:

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_____

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AREAS OF CONCERN:

Problems Sleeping	☐ Yes	☐ No
Feeling Sad/Depressed	☐ Yes	☐ No
Changes in Appetite	☐ Yes	☐ No
Racing Thoughts	☐ Yes	☐ No
Irritable	☐ Yes	☐ No
Feeling like people are out to get me	☐ Yes	☐ No
Hearing Voices	☐ Yes	☐ No
Anxiety/Feeling fearful	☐ Yes	☐ No
Unwanted thoughts	☐ Yes	☐ No
Intentionally Cutting Self	☐ Yes	☐ No
Purging	☐ Yes	☐ No
Suicidal Thoughts	☐ Yes	☐ No
History of Physical Abuse or Assault	☐ Yes	☐ No
History of Sexual Abuse or Assault	☐ Yes	☐ No
History of previous suicide attempts	☐ Yes	☐ No
History of hospitalization for mental health reasons	☐ Yes	☐ No
History of previous therapy or counseling	☐ Yes	☐ No
Family members with a history of mental illness	☐ Yes	☐ No
History of concussion or other head injury?	☐ Yes	☐ No

PLEASE LIST ANY OTHER AREAS OF CONCERN:

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_____

CONCERNS RELATED TO SEXUALITY OR SEXUAL IDENTITY:

_____

_____

Medications		
LIST OF PRESCRIBED DRUGS AND OVER-THE-COUNTER DRUGS, SUCH AS VITAMINS AND INHALERS (or provide list)		
Name of Drug	Strength	Frequency Taken
Continue bellow as needed		

NON-PRESCRIBED DRUGS/SUBSTANCE USE OR ABUSE:

Nicotine	☐ Current	☐ Past	☐ Tried	☐ Never
Alcohol	☐ Current	☐ Past	☐ Tried	☐ Never
Amphetamines	☐ Current	☐ Past	☐ Tried	☐ Never
Opioids	☐ Current	☐ Past	☐ Tried	☐ Never
Cocaine	☐ Current	☐ Past	☐ Tried	☐ Never
Hallucinogens (LSD, mushrooms, peyote)	☐ Current	☐ Past	☐ Tried	☐ Never
Marijuana	☐ Current	☐ Past	☐ Tried	☐ Never
Ecstasy	☐ Current	☐ Past	☐ Tried	☐ Never
Heroin	☐ Current	☐ Past	☐ Tried	☐ Never
Other	☐ Current	☐ Past	☐ Tried	☐ Never
Other	☐ Current	☐ Past	☐ Tried	☐ Never