NEW PATIENT QUESTIONAIRE

Patient Name :

WHAT IS THE SPECIFIC REASON FOR YOUR VISIT?

Have you seen a counselor, psychologist, psychiatrist or other mental health professional before? Psychiatric history

No ☐ **Yes** ☐

If so:

Prior outpatient alcohol / substance abuse treatment

No ☐ **Yes** ☐

If so:

Prior outpatient treatment was successful?

No ☐ **Yes** ☐

Number of prior psychiatrist hospitalization?

Date of last Alcohol/substance abuse treatment?

Involuntary hospitalization in past?

Mother:

Age:

Living:

Deceased:

Cause of death:

If deceased, His age at time of his death YOUR age at his time of death

OCCUPATION:

HEALTH:

Frequency of contact with him: Are you/have been close to him?

During your childhood, did you live any significant period of time with anyone other than your natural parents?

No **Yes**

If so, please give the person's name and relationship to you

Name:

Relationship to you:

Mood Disorder Questionnaire

Name: **Date:**

Instructions: Complete this questionnaire and give it back to your doctor. Take your time and answer all the questions as best you can.

1. Has there ever been a period of time when you were not your usual self and...

No **Yes** ..... you felt so good or hyper that other people thought you were not normal self or you were so hyper that you got into trouble?

No **Yes** ..... You were so irritable that you shouted at people or started fights or argument?

No **Yes** ..... you felt so much more self-confident than usual?

No ☐	Yes ☐	..... you got much sleep than usual and found you didn't really miss it?
No ☐	Yes ☐	..... you were much more talkative or spoke much faster than usual?
No ☐	Yes ☐	..... thoughts raced through your head or you couldn't slow your mind down?
No ☐	Yes ☐	..... you were so easily distracted by things around you that you had trouble concentrating or staying on track?
No ☐	Yes ☐	..... you had more energy than usual?
No ☐	Yes ☐	..... you were much more active or did many more things than usual?
No ☐	Yes ☐	..... you were much more social or outgoing than usual; for example, you telephoned friends in the middle of the night?
No ☐	Yes ☐	..... you much more interested in sex than usual?
No ☐	Yes ☐	..... you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?
No ☐	Yes ☐	..... spending money got you or family into trouble?

Questionnaire Part A | Self Evaluation

Patient's Name: _____ **Date:** _____

Instructions: The questions below are designed to help your doctor evaluate patients with anxiety symptoms. Keep in mind, a high score on this questionnaire does not necessarily mean that you have an anxiety disorder - only an evaluation by a physician can make a determination. Answer the questions below as accurately as you can; these will help your doctor make a diagnosis.

Please circle YES or NO for the following questions, based on your experience in the past MONTH:

Have you been bothered by unpleasant thoughts or images that repeatedly enter your mind, such as:

1. Concern with contamination (dirt, germs, chemicals, radiation) or acquiring a Serious illness such as AIDS? No ☐ Yes ☐

2. Over concern with keeping objects (clothing, groceries, and tools) in perfect order or arrange exactly? No ☐ Yes ☐

3. Images of death or other horrible events? No ☐ Yes ☐

4. Personally unacceptable religious or sexual thoughts? No ☐ Yes ☐

Have you been worried a lot about terrible things happening, such as?

5. Fire, burglary or flooding of the house? No ☐ Yes ☐

6. Accidently hitting a pedestrian with your car or letting it roll down a hill? No ☐ Yes ☐

7. Spreading an illness (giving someone AIDS)? No ☐ Yes ☐

8. Losing something valuable? No ☐ Yes ☐

9. Harm coming to loved one because you weren't careful enough? No ☐ Yes ☐

Have you been worried about acting on an unwanted and senseless urge or impulse, such as?

10. Physically harming a loved one, pushing a stranger in front of a bus, steering your cart into oncoming traffic; inappropriate sexual contact; or poisoning dinner guests? No ☐ Yes ☐

Have you felt driven to perform certain acts over and over again, such as?

11. Excessive or ritualized washing, cleaning or grooming? No ☐ Yes ☐

12. Checking light switches, water faucets, the stove, door locks or the emergency brake? No ☐ Yes ☐

13. Counting; arranging; evening-up behaviors (making sure socks are at the same height)? No ☐ Yes ☐

14. Collecting useless objects or inspecting the garbage before it thrown out? No ☐ Yes ☐

15. Repeating routines actions (in/out of chair, going through doorway, relighting cigarette)?	No ☐	Yes ☐
16. Needing to touch objects or people?	No ☐	Yes ☐
17. Unnecessary rereading or rewriting; reopening envelopes before they are mailed?	No ☐	Yes ☐
18. Examining your body for signs of illness?	No ☐	Yes ☐
19. Avoiding colors ("red" means blood), numbers ("13" is unlucky) or names (Those that start with "D" signify death) that is associated with dreaded events or Unpleasant thoughts?	No ☐	Yes ☐
20. Needing to "confess" or repeatedly asking for reassurance that you said or did something correctly?	No ☐	Yes ☐

Patient Self - Evaluation

Instruction: The following questions refer to the repeated thoughts, images, urges or behaviors identified in Part A. Consider your experience during the past 30 days when selecting an answer.

	0 None	1 Mild(less than 1 hour)	2 Moderate(1 to 3 hours)	3 Severe(3 to 8 hours)	5 Extreme(more than 8 hours)
1. On average how much time is occupied by those thoughts and behaviors?	☐	☐	☐	☐	☐
2. How much distress do they cause you?	☐	☐	☐	☐	☐
3. How hard it is for you to control them?	☐	☐	☐	☐	☐
4. How much do they cause you to avoid doing anything, going anywhere or being with	☐	☐	☐	☐	☐

anyone? 5. How much do they interfere with school, work or your social or family life?	☐	☐	☐	☐	☐

PLEASE BRING THE FOLLOWING ON YOUR VISIT:

1. **BRING ALL THE LAB RESULTS AND MR IF ADMITTED AT THE HOSPITAL**
2. **CURRENTLY TAKING RX BOTTLES OR MEDICATIONS AND DOSAGE LIST**
3. **IF THE PATIENT IS A MINOR NEED TO BE SEEN WITH PARENTS FREELY AVAILABLE TO PROPERLY EVALUATE THE PATIENT.**
4. **PLEASE NO LITTLE KIDS**
5. **PLEASE CALL YOUR INSURANCE AND ASK FOR YOU CO-PAY BEFORE YOUR VISIT.**