

Comprehensive Psychiatric Associates

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Mental Health Services for
Children, Adolescents, Adults, and Families

www.WellPsych.com

Client Name: _____

Appointment Date: _____

Appointment Time: _____

Clinician: _____

You have an appointment for a mental health consultation at the date and time shown above.

Enclosed please find information regarding our clinical services, fee and billing information, and some forms and questionnaires. Please complete the enclosed *Questionnaire for New Patients*, read and sign the *Financial Policies Agreement* and *Client Consent to Treatment & to Release of Information* forms, and bring all of these with you to your first appointment. This will allow us to use our appointment time more efficiently. If you have any copies of prior psychiatric evaluation reports, reports of psychological testing, or any other documentation of prior mental health evaluation or treatment that is not already in your record at Comprehensive Psychiatric Associates, please bring copies of these documents with you.

We generally try to schedule the initial consultation with a clinician who will be appropriate to provide any ongoing treatment that is indicated, based on what you told our staff when you called to schedule the consultation. However, in some cases the clinician providing the initial consultation may recommend that a different clinician would be more well qualified to provide whatever treatment is indicated.

If you need to cancel or reschedule your first appointment, please call the office to let us know as far in advance as possible, but at least 72 hours prior to the scheduled appointment. If an initial appointment is cancelled with less than 72 hours prior notice or missed without prior cancellation, we may not be able to reschedule.

Please feel free to call the office if you have any questions.

QUESTIONNAIRE FOR NEW PATIENTS

Please complete this questionnaire as fully as possible and bring the completed questionnaire with you when you come for your appointment. If you need additional space, please use the back of the page. All of the information you provide on this questionnaire will be treated with complete confidentiality.

Today's Date _____

Name _____ D. O. B. _____ Age _____

Phone: Home _____ Work _____ Cell _____

Address _____

City _____ ST _____ Zip _____

Your Primary Physician _____

Address _____

Phone _____

Who referred you to us? _____

I. Please state the reason you are seeking consultation.

What is the problem (or problems) you would like help with?

When and how did the problem(s) begin?

What has been done so far to try to alleviate the problem(s)?

II. Substance Use

Do you smoke cigarettes? Yes No

IF YES, how many cigarettes daily? _____ For how many years? _____

Are you frequently exposed to second-hand smoke at work or at home? Yes No

Do you drink caffeinated beverages (coffee, tea, or caffeinated soft drinks)? Yes No

IF YES, how many caffeinated drinks per day? _____

Do you drink alcohol? Yes No

IF YES, how many drinks per week? _____

Have you or anyone close to you ever thought that you had a drinking problem? Yes No

Have you ever felt you ought to cut down on your drinking? Yes No

Have people ever annoyed you by criticizing your drinking? Yes No

Have you ever felt bad or guilty about your drinking? Yes No

Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? Yes No

Have you used "recreational" drugs (marijuana, cocaine, speed, etc.)? Yes No

IF YES, what drugs?

Have you or anyone close to you ever thought that you had a drug problem? Yes No

Have you ever abused or misused prescription drugs? Yes No

III. Psychiatric Treatment History

Have you ever been hospitalized for psychiatric treatment? Yes No IF YES, please specify:

Dates of hospitalization: from _____ to _____. Name of hospital: _____

Reason for hospitalization: _____

Was the hospital treatment helpful?

Dates of hospitalization: from _____ to _____. Name of hospital: _____

Reason for hospitalization: _____

Was the hospital treatment helpful?

Are you currently seeing a therapist or counselor? Yes No IF YES, please specify:

Name of therapist: _____ Seeing since _____

What town is therapist in? _____ Telephone number _____

Has this therapy been helpful?

Are you currently taking any medication for treatment of psychiatric or emotional problems?

Yes No IF YES, please specify:

Name of medication	Dose and frequency	Taken when (dates)	Benefits and/or side effects

Have you seen other therapists or counselors in the past? Yes No IF YES, please specify:

Name of therapist: _____ Dates of counseling: from _____ to _____ .

Was treatment helpful?

Name of therapist: _____ Dates of counseling: from _____ to _____ .

Was treatment helpful?

Have you taken other medications in the past for treatment of psychiatric or emotional problems?

Yes No IF YES, please specify:

Name of medication	Dose and frequency	Taken when (dates)	Benefits and/or side effects

IV. Medical History

Overall, would you say your physical health is:

Excellent Very good Good Fair Poor

Have you suffered from any of the following medical problems? (check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> allergic reactions to medications | <input type="checkbox"/> high blood pressure |
| <input type="checkbox"/> other allergies | <input type="checkbox"/> hepatitis |
| <input type="checkbox"/> asthma | <input type="checkbox"/> hormonal problems |
| <input type="checkbox"/> AIDS (or infection with HIV) | <input type="checkbox"/> kidney problems |
| <input type="checkbox"/> cancer | <input type="checkbox"/> liver problems |
| <input type="checkbox"/> cataract | <input type="checkbox"/> prostate illness |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> seizures |
| <input type="checkbox"/> glaucoma | <input type="checkbox"/> stroke |
| <input type="checkbox"/> head injuries | <input type="checkbox"/> surgery |
| <input type="checkbox"/> severe or recurrent headaches | <input type="checkbox"/> sexually-transmitted disease |
| <input type="checkbox"/> hearing impairment | <input type="checkbox"/> thyroid condition |
| <input type="checkbox"/> heart disease | <input type="checkbox"/> ulcers |
| <input type="checkbox"/> recurrent gastrointestinal illness (nausea, vomiting, constipation, or diarrhea) | |
| <input type="checkbox"/> hospitalization for medical illness in the last 5 years | |
| <input type="checkbox"/> other medical problems (describe) | |

IF YES to any of above, please provide details:

Are you concerned about the quality of your sleep? Yes No
 IF YES Trouble falling asleep? Yes No
 Frequent waking during the night? Yes No
 Wake up early in the morning and can't fall back to sleep? Yes No
 Don't feel rested in the morning? Yes No

Do you frequently feel fatigued, exhausted, or sleepy during the day? Yes No

Has your weight changed significantly in the last year? Yes No

IF YES Weight gain? How much _____ lbs. Weight loss? How much _____ lbs.

Date of your last physical examination: _____

Are you currently taking any medication other than the psychiatric medications listed above (include prescription medications, birth control pills, and over-the-counter medicines, such as cold or allergy preparations)? Yes No IF YES, please specify below:

Name of medication	Dose and frequency	Taken when (dates)	Why taking this medication?

Are you currently sexually active? Yes No

How would you describe your sexual orientation? Heterosexual Gay/Lesbian Bisexual

Females Only

IF you are sexually active with a man, are you using any form of birth control? Yes No

IF YES, what form of birth control do you use?

Date of your last gynecological examination _____

Do you have any problems related to your menstrual periods, such as irregular periods, prolonged or especially painful periods, or excessive bleeding? Yes No IF YES, please describe:

Do your symptoms (anxiety, depression, other psychiatric symptoms) vary according to any pattern during the course of your menstrual cycle? For example, do you become more depressed, anxious, or irritable before your period? Yes No IF YES, please describe:

Marital status Married How long? _____ Separated How long? _____
Divorced How long? _____ Widowed How long? _____
Never Married

Have you been married previously? Yes No IF YES, please list dates of previous marriages:

If you are currently married or living with a partner, are you now or have you in the past experienced significant conflicts in your relationship? Yes No IF YES, please describe:

Do any family/household members currently suffer from significant physical health problems?
Yes No IF YES, please describe:

Do any family/household members currently suffer from significant mental/emotional health problems?
Yes No IF YES, please describe:

Are there any other significant stresses currently affecting your family life (e.g., financial concerns, health problems, extended family concerns or conflicts, job problems, etc.)?
Yes No IF YES, please describe:

Your educational attainment (check highest level obtained):

- | | |
|--|---|
| <input type="checkbox"/> 8th grade or less | <input type="checkbox"/> some college or associate degree |
| <input type="checkbox"/> some high school | <input type="checkbox"/> college graduate |
| <input type="checkbox"/> high school graduate or equivalency (GED) | <input type="checkbox"/> advanced college degree |

Your occupation _____

Work hours per week (approximate): _____

How long have you been in your current position? _____

What is your religion? _____

Do you consider yourself to be:

- Very religious Moderately religious Slightly religious Not at all religious

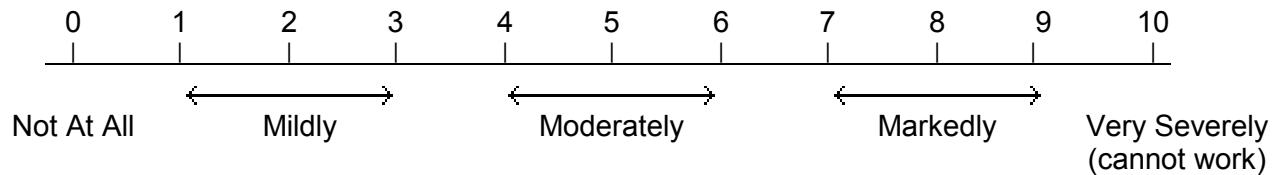
VI. Family History Have any of your biological relatives had the following problems?

	Father	Mother	Siblings	Your children	Other family
Depression					
Anxiety or nervousness					
Alcohol abuse					
Drug abuse					
Schizophrenia					
Bipolar disorder (manic depressive)					
Obsessive-compulsive disorder					
Hospitalized for psychiatric problem					
Learning difficulties or Hyperactive as child					
Hyperactivity					
Mental retardation					
Other psychiatric problem					
Suicide					
Criminal behavior					
Unknown					

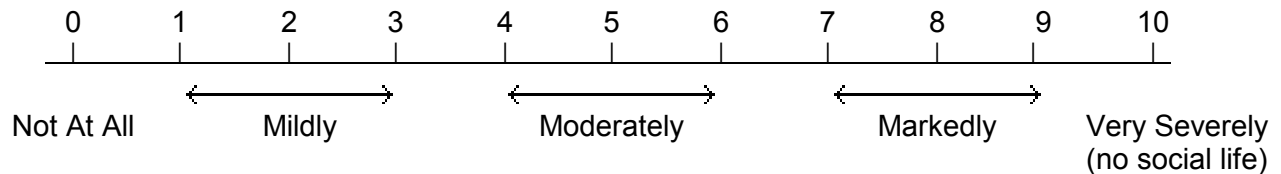
VII. Please indicate how much your problems have been interfering with your daily life

Circle one number above each line.

Because of my problems, my **WORK** is impaired:



Because of my problems, my **SOCIAL LIFE / LEISURE** is impaired:



Because of my problems, my

FAMILY LIFE AND ABILITY TO CARRY OUT HOME RESPONSIBILITIES are impaired:

