NORTH ALABAMA
FAMILY PSYCHIATRY
&
COUNSELING

Adult Initial Assessment / Patient Questionnaire

Patient Name: _____ **Date:** _____

Age: _____ **Date of Birth:** _____/_____/_____

Please read the following questions and answer to the best of your ability by placing a checkmark in the appropriate boxes or filling in the blank as directed. Your cooperation is appreciated.

Referred by: _____

Please describe, in detail, the present problem including when the problem started, how often it occurs and what stressors may contribute to the problem.

_____

_____

_____

_____

_____

_____

_____

_____

Please check ALL of the following symptoms or thoughts that apply to you **AT THIS TIME or during the past six months:**

- □ Depressed mood
- □ Diminished interests or pleasure
- □ Sleep disturbance
- □ Fatigue
- □ Change in appetite
- □ Hopelessness
- □ Pleasure in few activities
- □ Weight change
- □ Agitation
- □ Excessive worry
- □ I feel like I am losing control.
- □ Irritability
- □ Poor Concentration
- □ Tension
- □ Feelings of panic
- □ Socially withdrawn
- □ Use of alcohol
- □ Use of other drugs
- □ Use of tobacco
- □ Anxiety in social settings
- □ Makes careless mistakes
- □ Does not complete tasks
- □ Difficulty organizing
- □ Forgetful
- □ Confusion
- □ Disorientation
- □ Compulsive checking / counting
- □ Indecisiveness
- □ People talk about me.
- □ Some people want to hurt me.
- □ I feel emotionally distant from others.
- □ I hear voices or sounds others do not hear.
- □ I see things others do not see.
- □ I smell things others do not smell.
- □ Racing thoughts
- □ I do risky or dangerous things.
- □ Little interest in sexual activity
- □ Sexual problems
- □ Gender concerns
- □ I don't like my body.
- □ Binge eating
- □ Self induced vomiting
- □ Laxative abuse
- □ Excessive fasting
- □ Intense fear of weight gain
- □ Impulsive
- □ I think about hurting myself.
- □ I have tried to hurt myself.
- □ Sometimes I wish I were dead.
- □ I think about hurting someone else.
- □ Exposed to a significant traumatic event
- □ Recurrent distressing dreams

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Suicide Risk Assessment:

Have you ever had feelings or thoughts that you didn't want to live? □ Yes □ No.

If YES, please answer the following. **If NO**, please skip to the next section.

Do you **currently** feel that you don't want to live? □ Yes □ No

How often do you have these thoughts?_____

When was the last time you had thoughts of dying? _____

Has anything happened recently to make you feel this way? _____

On a scale of 1 to 10, (ten being strongest) how strong is your desire to kill yourself currently? _____

Would anything make it better? _____

Have you ever thought about how you would kill yourself? _____

Is the method you would use readily available? _____

Have you planned a time for this? _____

Is there anything that would stop you from killing yourself? _____

Do you feel hopeless and/or worthless? _____

Have you ever tried to kill or harm yourself before? _____

Do you have access to guns? If yes, please explain. _____

_____

Psychiatric History:

Do you have a prior psychiatric diagnosis? If so, what is it and when did you receive it?

_____

_____

_____

_____

Outpatient treatment □ Yes □ No If yes, Please describe when, by whom, and nature of treatment.

By Whom Dates Treated Reason

_____

_____

_____

_____

Psychiatric Hospitalization □ Yes □ No If yes, describe for what reason, when and where.

Where Dates Hospitalized Reason

_____

_____

_____

_____

Past Psychiatric Medications: Please list all psychiatric medications you have ever been prescribed.

_____

_____

_____

_____

If you have ever taken any of the following medications, please check them and indicate the dates, dosage, and how helpful they were (if you can't remember all the details, just write in what you do remember).

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Dates Dosage Response/Side-Effects

Antidepressants

□ Prozac (fluoxetine) _____
□ Zoloft (sertraline) _____
□ Luvox (fluvoxamine) _____
□ Paxil (paroxetine) _____
□ Celexa (citalopram) _____
□ Lexapro (escitalopram) _____
□ Effexor (venlafaxine) _____
□ Pristiq (desvenlafaxine)_____
□ Cymbalta (duloxetine) _____
□ Fetzima (levomilnacipran)_____
□ Brintellix (vortioxetine)_____
□ Wellbutrin (bupropion) _____
□ Viibryd (vilazodone)_____
□ Remeron (mirtazapine) _____
□ Serzone (nefazodone) _____
□ Anafranil (clomipramine) _____
□ Pamelor (nortrptyline) _____
□ Tofranil (imipramine) _____
□ Elavil (amitriptyline) _____
□ Other _____

Mood Stabilizers

□ Tegretol (carbamazepine)_____
□ Lithium_____
□ Depakote (valproate) _____
□ Lamictal (lamotrigine) _____
□ Tegretol (carbamazepine) _____
□ Topamax (topiramate) _____
□ Other _____

Antipsychotics/Mood Stabilizers

□ Haldol (haloperidol)_____
□ Prolixin (fluphenazine)_____
□ Risperdal (risperidone)_____
□ Seroquel (quetiapine)_____
□ Geodon (ziprasidone)_____
□ Clozaril (clozapine)_____
□ Invega (paliperidone)_____
□ Abilify (aripiprazole)_____
□ Zyprexa (olanzapine)_____
□ Saphris (asenapine)_____
□ Fanapt (iloperidone)_____
□ Latuda (lurasidone)_____
□ Rexulti (brexpiprazole)_____
□ Vraylar (cariprazine)
□ Other _____

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Anxiolytics

□ Vistaril/Atarax (hydroxyzine)_____
□ BuSpar (buspirone)_____
□ Xanax(alprazolam)_____
□ Ativan (lorazepam)_____
□ Valium (diazepam) _____
□ Klonopin (clonazepam)_____
□ Other _____

Sedative/Hypnotics

□ Ambien (zolpidem) _____
□ Sonata (zaleplon) _____
□ Rozerem (ramelteon)_____
□ Silenor (doxepin)_____
□ Restoril (temazepam) _____
□ Desyrel (trazodone) _____
□ Belsomra (suvorexant)
□ Other _____

ADHD medications

□ Adderall or XR (dextroamphetamine/amphetamine)_____
□ Ritalin or LA/SR (methylphenidate)_____
□ Concerta (methylphenidate) _____
□ Methylphenidate ER_____
□ Focalin or XR (dexmethylphenidate)_____
□ Daytrana (methylphenidate transdermal)_____
□ Vyvanse (lisdexamphetamine)_____
□ Aptensio XR (methylphenidate)_____
□ Quillivant XR (methylphenidate)_____
□ Evekeo (amphetamine)_____
□ Tenex (guanfacine)_____
□ Intuniv (guanfacine ER)_____
□ Catapres (clonidine)_____
□ Kapvay (clonidine ER)_____
□ Strattera (atomoxetine)_____
□ Other _____

Family Psychiatric History: Has anyone in your family been diagnosed with or treated for:

Bipolar disorder	□Yes □No	Schizophrenia	□ Yes □ No
Depression	□Yes □ No	Post-traumatic stress	□ Yes □ No
ADHD	□Yes □ No	Learning Disability	□ Yes □ No
Autism	□ Yes □ No	Intellectual Disability	□ Yes □ No
Anxiety	□ Yes □ No	Alcohol abuse	□ Yes □ No
Anger	□ Yes □ No	Other substance abuse	□Yes □ No
Suicide	□ Yes □ No	Violence	□ Yes □ No

If yes, who had each problem?

_____

_____

Has any family member been treated with a psychiatric medication? □ Yes □ No If yes, who was treated, what medications did they take, and how effective was the treatment?

_____

_____

Past Medical History:

Allergies_____Current Weight _____ Height _____

Primary Care Physician_____Phone#_____

Date and place of last physical exam: _____

List ALL current prescription medications and how often you take them: (if none, write none)

_____

_____

_____

_____

_____

_____

_____

_____

Current over-the-counter medications or supplements:

_____

_____

Current medical problems:

_____

_____

Past medical problems, non-psychiatric hospitalization, or surgeries:

_____

_____

Have you ever received treatment for any of the following medical conditions?

	Yes	**No**
Neurological impairment	□	□
Seizure disorder	□	□
Visual loss / impairment	□	□
Hearing loss / impairment	□	□
Dementia	□	□
GI disorder	□	□
Obesity	□	□
Significantly underweight	□	□
Cirrhosis	□	□
Hepatitis	□	□
Heart condition	□	□
Hypertension	□	□
Asthma/respiratory problems	□	□
Emphysema	□	□
Chronic bronchitis	□	□

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	Yes	No
Tuberculosis / +PPD	□	□
Cancer	□	□
Thyroid disease	□	□
Diabetes	□	□
Irregular menstrual periods	□	□
Musculoskeletal condition	□	□
HIV / AIDS / Related condition	□	□

Other_____

For women only: Date of last menstrual period _____

Are you currently pregnant or do you think you might be pregnant? □ Yes □ No.

Are you planning to get pregnant in the near future? □ Yes □ No

Birth control method_____

How many times have you been pregnant? _____ How many live births? _____

Have you ever been treated for a nutritional problem?	□ Yes	□ No
Do you make yourself sick because you feel uncomfortably full?	□ Yes	□ No
Do you worry you have lost control over how much you eat?	□ Yes	□ No
Have you recently lost more than 14 pounds in a 3-month period?	□ Yes	□ No
Do you believe yourself to be fat when others say you are too thin?	□ Yes	□ No
Would you say that food dominates your life?	□ Yes	□ No

Are you experiencing any physical pain? □Yes □ No

Substance Use:

Have you ever been treated for alcohol or drug use or abuse? □ Yes □ No

If yes, for which substances?_____

If yes, where were you treated and when?_____

How many days per week do you drink any alcohol? _____

What is the least number of drinks you will drink in a day? _____

What is the most number of drinks you will drink in a day? _____

In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day?_____

Have you ever felt you ought to cut down on your drinking or drug use? □ Yes □ No

Have people annoyed you by criticizing your drinking or drug use? □ Yes □ No

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

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

Do you think you may have a problem with alcohol or drug use? □ Yes □ No

Have you used any street drugs in the past 3 months? □ Yes □ No

If yes, which ones? _____

Have you ever abused prescription medication? □ Yes □ No

If yes, which ones and for how long? _____

_____

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Check if you have tried any of the following:

□ Methamphetamine
□ Stimulants (pills)
□ Hallucinogens
□ Synthetic drugs
□ Methadone
□ Tranquilizer/sleeping pills
□ Cocaine
□ LSD/ PCP
□ Marijuana
□ Pain Killers (not as a prescription)
□ Alcohol
□ Ecstasy
□ Other _____

How many caffeinated beverages do you drink a day? Coffee _____ Sodas _____ Tea _____

Tobacco History:

How you ever smoked cigarettes? □ Yes □ No
Currently? □ Yes □ No
How many packs per day on average? _____ How many years? _____
In the past? □Yes □ No How many years did you smoke? _____ When did you quit? _____
Pipe, cigars, or chewing tobacco: Currently? □ Yes □ No In the past? □ Yes □ No
What kind? _____ How often per day on average? _____ How many years? _____

Family Background and Childhood History:

Were you adopted? □ Yes □ No Where did you grow up? _____
List your siblings and their ages: _____
_____
What was your father's occupation? _____
What was your mother's occupation? _____
Did your parents' divorce? □ Yes □ No If so, how old were you when they divorced? _____
If your parents divorced, who did you live with?_____
Describe your father and your relationship with him: _____
_____
Describe your mother and your relationship with her:_____
_____
How old were you when you left home? _____
Has anyone in your immediate family died? _____
Who and when?_____

Trauma History:

Do you have a history of being abused emotionally, sexually, physically or by neglect? □ Yes □ No.
Please describe when, where and by whom: _____
_____

Educational History:

Highest Grade Completed? _____ Where?_____
Did you attend college? _____ Where? _____Major? _____
What is your highest educational level or degree attained? _____

Occupational History:
Are you currently: □ Working □ Student □ Unemployed □ Disabled □ Retired
How long in present position? _____
What is/was your occupation? _____
Where do you work? _____
Have you ever served in the military? _____ If so, what branch and when? _____
Honorable discharge □ Yes □ No Other type discharge _____

Relationship History and Current Family:
Are you currently: □ Married □ Partnered □ Divorced □ Single □Widowed
How long? _____
If not married, are you currently in a relationship? □ Yes □ No If yes, how long? _____
Are you sexually active? □ Yes □ No
How would you identify your sexual orientation?
□ straight/heterosexual □ lesbian/gay/homosexual □ bisexual □ transsexual
□ unsure/questioning □ asexual □ prefer not to answer □ other_____
What is your spouse or significant other's occupation? _____
Describe your relationship with your spouse or significant other: _____
_____
Have you had any prior marriages? □ Yes □ No. If so, how many? _____
How long? _____
Do you have children? □ Yes □ No If yes, list ages and gender: _____
_____
Describe your relationship with your children: _____
List everyone who currently lives with you: _____
_____

Legal History:
Have you ever been arrested? _____
Do you have any pending legal problems? _____

Spiritual Life:
Do you belong to a particular religion or spiritual group? □ Yes □ No Group: _____
If yes, what is the level of your involvement? _____
Do you find your involvement helpful during this illness, or does the involvement make things more difficult or stressful for you? □ more helpful □ stressful