Integrative Psychiatry

NEW PATIENT QUESTIONAIRE

Patient Name_____ Referred by: _____

Main Problem and Current Symptoms

Please explain why you are seeking treatment:

How long have you been experiencing your current symptoms?

Have you ever sought treatment (medicine or therapy) for your current symptoms?

___ Yes ___ No

If yes, who did you see and what was the treatment?

Please place an **X** in front of each of the following you are currently experiencing:

___ thoughts of self-harm
___ thoughts of harming someone else
___ irritable mood or anger towards others
___ difficulty remembering things
___ confusion
___ racing thoughts
___ depression
___ feeling too “high” or sped up
___ using drugs or alcohol to relieve stress
___ feeling physically tense
___ experiencing unreal or strange thoughts
___ hearing or seeing “unreal” things
___ anxiety
___ sleep problems

Are your symptoms causing difficulties in any of the following areas:

___ job problems
___ school problems
___ move
___ breakup or divorce
___ death of a loved one
___ physical symptoms
___ financial problems
___ drug/alcohol problems
___ sexual problems
___ legal problems
___ conflict with work
___ conflict with significant other
___ conflict with parents
___ conflict with children

Psychiatric History

Have you ever been hospitalized for a psychiatric condition? ___ Yes ___ No

If yes, when, and where?

Have you ever attempted suicide? ___ Yes ___ No

Have you ever engaged in any self-harming behavior? ___ Yes ___ No

Have you been a victim of physical, sexual, or emotional abuse? ___Yes ___No

Have you been arrested for a criminal issue? ___Yes ___No

Have you ever received any form of therapy in the past? ___Yes ___No

If yes, who is your therapist(s) and for how long did you see them?

Have you ever received any treatment (medications, inpatient, IOP, etc.) for drugs or alcohol?

If yes, please describe:

Have you ever received any of the following:

___ ECT ___ TMS ___ Spravato ___ IV/IM Ketamine

If so, please specify when, where, and if it helped your symptoms:

Medications

Please list **ALL** of your **CURRENT** medications, prescription and over-the-counter:

Medication Name	Dose	Frequency	Duration	Prescriber

Please list those **PAST PSYCHIATRIC** medications:

Medication Name	Dose	Frequency	Duration	Reason for stopping

Medical and Surgical History

Condition	Treating Physician

Please list any current and past medical conditions:

Please list any prior surgeries:

Date	Physician	Surgery

Allergies:

Please list all known drug/food/environmental allergies:

Allergy	Reaction	Allergy	Reaction

General Physical Health

In the list of symptoms below, please check the ones you are CURRENTLY experiencing:

System	Symptoms	Other
General	_ fever _ chills _ fatigue _ weight change	
Eyes	_ eye pain _vision problems _ discharge from eye	
Ear/Nose/Throat	_ nosebleeds _ sore throat _ loss of hearing	
Cardiovascular	_ chest pain _palpitations _ foot/leg swelling	
Respiratory	_ cough _ wheezing _shortness of air _ snoring	
Gastrointestinal	_ constipation _nausea/vomiting _ diarrhea _heartburn _ abdominal pain _ poor appetite	
Genitourinary	_ pain in groin area _ difficulty urinating _ sexual difficulty	
Musculoskeletal	_ joint pain _ joint stiffness _muscle weakness	
Skin/Hair	_ itching _ dry skin _ rash _ skin lesions	
Neurological	_ headaches _ fainting _ seizure _ dizziness	
Heme/Lymph	_ easy bleeding _ easy bruising _ anemia	
Menstrual	_ irregular periods _ excessive pain/bleeding	
Endocrine	_ hot flashes _ growth issues _ erectile dysfunction	

Substance Use History

If you currently drink alcohol or use drugs:

Have you ever felt you should cut back on your use? ___ Yes ___ No

Have people criticized your drinking/drug habits? ___ Yes ___ No

Have you ever felt bad/guilty about your drinking/drug habits? ___ Yes ___ No

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

Please check the boxes that correspond to your **CURRENT** use of the following:

Substance	None	Less than once a month	1 – 3 times monthly	1 – 6 days a week	Daily or more	Age or year of first Use
Alcohol						
Tobacco						
Marijuana						
Sedatives (Valium, Xanax, Klonopin)						
Opiates or Narcotics						
Stimulants (meth, speed, crank)						
Cocaine						
Hallucinogens						
Inhalants (paint, butane, nitrous oxide)						

Please check the boxes that correspond to your **PAST** use of the following:

Substance	None	Less than once a month	1 – 3 times monthly	1 – 6 days a week	Daily or more	Age or year of first Use
Alcohol						
Tobacco						
Marijuana						
Sedatives (Valium, Xanax, Klonopin)						
Opiates or Narcotics						
Stimulants (meth, speed, crank)						

Cocaine						
Hallucinogens						
Inhalants (paint, butane, nitrous oxide)						

Family History

Is there a history of mental illness or addiction (alcohol or drugs) in:

Biological parents? ___ Yes ___ No

If yes, please specify:

Siblings? ___ Yes ___ No

If yes, please specify:

Children? ___ Yes ___ No

If yes, please specify:

Anyone else in your family? ___ Yes ___ No

If yes, please specify:

Does anyone in your family cope with a medical illness? If so, please specify:

Social History

Are you currently employed or own a business?

What is your current living situation?

Are you currently in a significant relationship? Divorced? Separated?

Do you have any children? If so, please list gender and ages.

What is your highest level of education?

Do you identify with a religion?

Do you practice a religion? If so, what?

Do you have any social activities or interests?

Do you have a social group or strong support system?

Have you ever served in the military? How long?

Do you currently exercise? How often?

Do you eat a balanced diet?

How often do you consume coffee/soda/caffeinated beverages?