CONFIDENTIAL PATIENT QUESTIONNAIRE AND RECORD

GENERAL INFORMATION

NAME_____**DATE:**_____

ADDRESS:
STREET_____

CITY_____**STATE**_____**ZIP**_____

HOME PHONE_____ **WORK**_____ **CELL**_____
DO WE HAVE YOUR PERMISSION TO CALL AND LEAVE A MESSAGE AT EACH OF THESE PHONE NUMBERS? ___Y ____N

BIRTH DATE_____**AGE**_____ **RELIGION**_____

OCCUPATION/EMPLOYER _____ **# OF YRS EMPLOYED THERE**_____

HEIGHT_____**WEIGHT**_____ **SEX: MALE __ FEMALE __ SS#**_____

 # CHILDREN _____ **NAMES, AGES AND GENDER OF CHILDREN** _____

_____ **# CHILDREN AT HOME** _____

INSURANCE COMPANY _____ **MEDICAL ALLERGIES** _____

FAMILY PHYSICIAN _____ **DATE LAST SEEN** _____

WHO TO CONTACT IN CASE OF EMERGENCY _____ **PHONE #** _____

EMAIL ADDRESS:_____ **DO YOU HAVE THE ABILITY TO RECEIVE TEXT MESSAGES? ___Y ____N**

MARITAL/EMPLOYMENT STATUS

CHECK THOSE WHICH APPLY: ___ MARRIED ___ SEPARATED ___ DIVORCED ___# OF PREV MARRIAGES ___ WIDOWED ___ SINGLE

SPOUSE (SIGNIFICANT OTHER) INFORMATION:
NAME _____**LENGTH OF MARRIAGE:** _____

IF PREVIOUSLY MARRIED, LENGTH OF MARRIAGES: _____

SPOUSE OCCUPATION/EMPLOYER_____ **# YRS TOGETHER:** _____ **AGE**_____

EDUCATION/MILITARY

CIRCLE HIGHEST LEVEL OF EDUCATION COMPLETED:
JR HIGH 6 7 8 HIGH SCHOOL 9 10 11 12 COLLEGE 1 2 3 4 GRADUATE SCHOOL 1 2 3 4 5 PhD. _____

CURRENT DIPLOMAS, DEGREES, CERTIFICATIONS HELD:
_____ **INSTITUTION** _____ **MAJOR** _____

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_____ **INSTITUTION** _____**MAJOR** _____

MILITARY SERVICE (Branch) _____ **# of YRS** _____ **DISCHARGE STATUS** _____

REASON FOR APPOINTMENT _____

RECENT TREATMENT FOR PROBLEM _____

PREVIOUS COUNSELING (INCLUDE NAME OF COUNSELOR, WHEN AND REASON)_____

WHO REFERRED YOU TO OUR OFFICE? _____

WHAT ARE THE MOST STRESSFUL PARTS OF YOUR LIFE CURRENTLY?

#1 _____

#2_____

#3_____

WHO OR WHAT MEANS DO YOU USE FOR EMOTIONAL SUPPORT NOW?

#1 _____

#2_____

#3_____

During my growing up years . . .

. . . my parents remained: **____ together** **____ separated**

. . . I lived primarily with my:

___ mother **___ stepfather**

___ father **___ adoptive parents**

___ stepmother **___ foster parents**

___ other (describe:_____)

. . . the # of siblings I had was: _____Their ages and birth order are_____

Please provide brief description of the occupation and personality of parental figures in your life:

Parental figure	His/her Occupation	His/her personality
Mother (or maternal Substitute)		
Father (or paternal Substitute)		

Please provide a brief description of family life growing up:_____
_____
_____
_____
_____

Personal and Family PSYCHIATRIC History		**Personal and Family MEDICAL History**	
Is there a history for any of the following in:		**Is there a history of the following in:**	
YOURSELF	**A BLOOD RELATIVE**	**YOURSELF**	**A BLOOD RELATIVE**
___Depression **___Anxiety Disorder** **___Substance Abuse** **___Suicide Attempt** **___Psychiatric Hospitalization** **___ Legal Problems** **___ Other (explain___** **_____** **_____** **_____)**	**___ Depression** **___ Anxiety Disorder** **___ Substance Abuse** **___ Suicide Attempt** **___Psychiatric Hospitalization** **___ Legal Problems** **___ Other (explain_____** **_____** **_____** **_____)**	**___High blood pressure** **___ Diabetes** **___ Alzheimer's/Dementia** **___ Stroke** **___ Heart attacks** **___ Cancer (Type_____)** **___ Asthma** **___Thyroid problem** **___ Chronic headaches** **___ Arthritis** **___ Stomach Ulcer** **___ Kidney Stone or failure** **___ Other (explain_____)**	**___ High blood pressure** **___ Diabetes** **___ Alzheimer's/Dementia** **___ Stroke** **___ Heart attacks** **___ Cancer (Type _____)** **___ Asthma** **___ Thyroid problem** **___ Chronic headaches** **___ Arthritis** **___ Stomach Ulcer** **___ Kidney Stone or failure** **___ Other (explain_____)**

HOSPITALIZATIONS/SURGERIES		
YEAR	**WHERE**	**NATURE OF ILLNESS**

CURRENT MEDICATION INFORMATION

MEDICATION	DOSAGE/FREQUENCY	REASON ON MEDICATION		PRESCRIBED BY

CAUSE OF DEATH OF IMMEDIATE FAMILY MEMBERS		
FAMILY MEMBER	**CAUSE OF DEATH**	**AGE**

SUBSTANCE USE HABITS (Please check all that apply)

Tobacco **CURRENT USE ___Yes ___ No PAST USE ONLY ___ Yes ___ No**	**Average # packs/day? _____** **For how many years? _____**
Alcohol **CURRENT USE ___ Yes ___ No PAST USE ONLY ___ Yes ___ No**	**Average # drinks/week? _____** **For how many years? _____** **How many DUI charges? _____Have you blacked out?____**
Coffee, tea, and caffeinated beverages **CURRENT USE ___ Yes ___ No PAST USE ONLY ___ Yes ___ No**	**Average cups/day? _____** **For how many years? _____**
Cocaine **CURRENT USE ___ Yes ___ No PAST USE ONLY ___ Yes ___ No**	**Average use/week? _____** **For how many years? _____**
Marijuana **CURRENT USE ___ Yes ___ No PAST USE ONLY ___ Yes ___ No**	**Average use/week? _____** **For how many years? _____**
Acid/Hallucinogens **CURRENT USE ___ Yes ___ No PAST USE ONLY ___ Yes ___ No**	**# trips in lifetime? _____**
Speed/Amphetamines **CURRENT USE ___ Yes ___ No PAST USE ONLY ___ Yes ___ No**	**Average use/week? _____** **For how many years? _____**
Other recreational substances **CURRENT USE ___ Yes ___ No PAST USE ONLY ___ Yes ___ No**	**Specify substance(s) _____** **For how many years? _____**

GENERAL ASSESSMENT

How is your mood in general?_____ Would it be described as up/down, sad, irritable, anxious?_____ _____ _____	**If one of these, how long would you stay in this mood?_____ When you leave this mood do you feel normal again?_____ How long does this feeling of normal last? _____ _____ _____**
How many minutes or hours would you say it takes for you to get to sleep?_____ Do you stay asleep as long as you want?_____ _____	**How is your appetite?_____ Has it increased/decreased? Have you gained or lost any weight?_____ If so, how much and over how long of a period? _____ _____**
Are you sexually active?_____ If so, do you experience any pain during intercourse?_____ Are you able to achieve orgasm? _____ Are there any issues in this area you wish to seek counseling for? _____ _____	**How would you describe your concentration and ability to focus? _____ How is your memory?_____ Has anyone complained about you forgetting things? _____ How is your motivation to get things done?_____ _____ _____**
Are there decisions that are hard to make or are they done impulsively? ____ Do you worry that people may be out to get you (kind of like paranoia)? ____ If yes, like what? ____ Any special fears or phobias? _____	**Do you ever see/hear things that are not there?_____ Do you ever feel things on your skin? _____ Do you have any compulsive behaviors (example: washing hands over and over, checking that doors are locked repetitively or making sure the stove has been turned off)? _____ _____**
Do you ever feel compelled to repeat words or phrases over and over?_____	**Have you ever found yourself restricting your food intake?_____ Have you ever forced yourself to purge or vomit or use some type of laxative? _____**
Have you ever gotten so down or depressed that you have tried to hurt yourself? _____	**Some people say "I would never kill myself but I wish I were dead"; this is called a "death wish". Have you ever felt this way?**
Have you ever had any thoughts about hurting anyone else? _____ If so, when?_____ If in the past are there any thoughts today?_____ _____	**Have you been taking care of your personal hygiene?(example: bathing, brushing teeth, combing hair) _____ _____ _____**

SPIRITUAL/RELIGIOUS

How would you say God fits into your life or do you even think He does?_____ _____ _____

How would you say your spiritual life would compare today from what it once was? Is it the same? Different? _____ _____ _____

Is there anything you would like to have happen to you spiritually in your future? _____ _____ _____

Is there a particular church that you attend? _____ _____ _____ _____

I agree to assessment and treatment by _____. I have read the "INFORMED CONSENT" and agree to abide by the terms stated. If applicable, I authorize the release of any medical/other information necessary to obtain an authorization for treatment and/or process an insurance claim.

_____ _____

SIGNATURE **DATE**

ADDITIONAL SPACE IF NEEDED

DEBRA M. KRAUS, M.A., LMHC/FOOTPRINTS COUNSELING LLC

Behavioral Health Screening Form

Client Name _____ **Date _____**

Date of Birth _____ **SS# _____**

Client phone/contact number _____

Please answer the following questions to the best of your ability. <u>All answers will be kept confidential.</u>

I.PHQ-9 PATIENT HEALTH QUESTIONNAIRE

Over the last **2 weeks,** how often have you been bothered by any of the following problems? *Please circle your responses on the right.*	Not at all	Several days	More than half the time	Nearly every day
1. Little interest or pleasure in doings things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or over eating	0	1	2	3
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking slowly that other people could have noticed. Or the opposite-being so fidgety or restless that you have been moving around a lot	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3

10. If you checked off ***any*** problems, how ***difficult*** have these problems made it for you to do your work, take care of things at home or get along with other people? *Please circle only one response.*

Not difficult at all **Somewhat difficult** **Very difficult** **Extremely difficult**

II. GAD-7 GENERAL ANXIETY QUESTIONNAIRE

Over the last **2 weeks,** how often have you been bothered by any of the following problems? *Please circle your responses on the right.*	Not at all	Several days	More than half the time	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

III. MDQ – MOOD QUESTIONNAIRE

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

… you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	Yes No
… you were so irritable that you shouted at people or started fights or arguments?	Yes No
… you felt much more self-confident than usual?	Yes No
… you got much less sleep than usual and found you didn't really miss it?	Yes No
… you were much more talkative or spoke much faster than usual?	Yes No
… thoughts raced through your head or you couldn't slow your mind down?	Yes No
… you were so easily distracted by things around you that you had trouble concentrating or staying on track?	Yes No
… you had much more energy than usual?	Yes No
… you were much more active or did many more things than usual?	Yes No
… you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	Yes No
… you were much more interested in sex than usual?	Yes No
… you did things that were usual for you or that other people might have thought were excessive, foolish or risky?	Yes No
… spending money got you or your family into trouble?	Yes No

2. If you checked **YES** to **more than one** of the above, have several of these ever happened during the same period of time? Yes No
3. How much of a problem did any of these cause you – like being unable to work, having family, money or legal troubles; getting into arguments or fights? *Please circle only one response*

No problem **Minor problem** **Moderate problem** **Serious problem**

4. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder? Yes No
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder? Yes No

IV. SSI-SA SUBSTANCE USE QUESTIONNAIRE

The questions that follow are about your use of alcohol and other drugs. Mark the response that best fits for you. Answer the questions in terms of your experience in the **past 6 months.**

1.	Have you used alcohol or other drugs? (Such as wine, beer, hard liquor, pot, coke, heroin or other Opioids, uppers, downers, hallucinogens, or inhalants)	Yes No
2.	Have you felt that you use too much alcohol or other drugs?	Yes No
3.	Have you tried to cut down or quit drinking or using alcohol or other drugs?	Yes No
4.	Have you gone to anyone for help because of your drinking or drug use? (Such as Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, counselors or a drug treatment Program)	Yes No
5.	Have you had any health problems? For example have you …	
	… had blackouts or other periods of memory loss?	Yes No
	… injured your head after drinking or using drugs?	Yes No
	… had convulsions, delirium tremens (“DTs”)?	Yes No
	… had hepatitis or other liver problems?	Yes No
	…felt sick, shaky, or depressed when you stopped?	Yes No
	… felt “coke bugs” or a crawling feeling under the skin after you stopped using drugs?	Yes No
	… been injured after drinking or using?	Yes No
	… used needles to shoot drugs?	Yes No
6.	Has drinking or other drug use caused problems between you and your family or friends?	Yes No
7.	Has your drinking or other drug use caused problems at school or at work?	Yes No
8.	Have you been arrested or had other legal problems? (Such as bouncing bad checks, driving while Intoxicated, theft, or drug possession)	Yes No
9.	Have you lost your temper or gotten into arguments or fights while drinking or using other Drugs?	Yes No
10.	Are you needing to drink or use drugs more and more to get the effect you want?	Yes No
11.	Do you spend a lot of time thinking about or trying to get alcohol or other drugs?	Yes No
12.	When drinking or using drugs, are you more likely to do something you wouldn’t normally do, Such as break rules, break the law, sell things that are important to you, or have unprotected sex With someone?	Yes No
13.	Do you feel bad or guilty about your drinking or drug use?	Yes No
14.	Have you ever had a drinking or other drug problem?	Yes No
15.	Have any of your family members ever had a drinking or drug problem?	Yes No
16.	Do you feel that you have a drinking or drug problem now?	Yes No