New Patient Intake Packet

This information is required by your provider to conduct your initial assessment. Please complete it as thoroughly as possible – the document is two-sided. If any section of the packet does not apply to your reason for seeking an appointment, feel free to skip that section. Please answer honestly; this information is confidential. Please arrive 30 minutes prior to your appointment to allow time for our staff to enter this information into your health record. If you have any questions while completing this packet, please call our office at 612 436 0295.

Adult Symptom Screener

Summary of Symptom Screening

Over the last 2 weeks, how often have you been bothered by the following problems?

	Not at all	Several days	More than half the days	Nearly every day
Feeling down, depressed, or hopeless	○	○	○	○
Little interest or pleasure in doing things	○	○	○	○
Feeling nervous, anxious or on edge	○	○	○	○
Not being able to stop or control worrying	○	○	○	○

The following questions relate to your experiences over the last 6 months:

	Yes	No
In the past 6 months, did you ever have a spell or an attack when all of a sudden you felt frightened, anxious or very uneasy?	○	○
In the past 6 months, did you ever have a spell or attack when for no reason your heart suddenly began to race, you felt faint, or you couldn't catch your breath?	○	○
Did any of these spells or attacks ever happen in a situation when you were not in danger or not the center of attention?	○	○

Please respond to the degree that the following problems have bothered you during the past week.

	Not at all	A little bit	Somewhat	Very much	Extremely
Fear of embarrassment causes me to avoid doing things or speaking to people.	○	○	○	○	○
I avoid activities in which I am the center of attention.	○	○	○	○	○
Being embarrassed or looking stupid are among my worst fears.	○	○	○	○	○

Please answer each question to the best of your ability.

	Yes	No
Have you experienced any of the following traumatic events: natural disaster (e.g., flood, hurricane, tornado, earthquake), fire, explosion, or industrial accident; transportation accident (e.g., car accident, plane crash); physical assault (e.g., being attacked, beaten up); sexual assault (e.g., rape, attempted rape, made to perform any type of sexual act through force or threat of harm); captivity or exposure to a war-zone; life-threatening illness or injury; sudden, unexpected death of or injury to someone close to you; or serious injury, harm, or death to someone else that you witnessed or caused?	○	○
Has this event caused any significant problems or symptoms that lasted for more than a month?	○	○

Please answer each question to the best of your ability.

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

Has there ever been a period of time when you were not your usual self and...	Yes	No
...spending money got you or your family into trouble?	○	○

The following questions relate to your eating habits:

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

	Yes	No
Have you ever been bothered by having to perform some ritual or act over and over that does not make sense?	○	○

The following questions relate to your alcohol and substance use:

	Never (Skip the next 2 questions)	Monthly or less	2 to 4 times a month	2 to 3 times a week	4 or more times a week
How often do you have a drink of Alcohol?	○	○	○	○	○

	1 to 2	3 to 4	5 to 6	7 to 9	10 or more
How many drinks containing alcohol do you have on a typical day when you are drinking?	○	○	○	○	○

	Never	Less than monthly	Monthly	Weekly	Daly or almost daily
How often do you have six or more drinks on one occasion?	○	○	○	○	○

	Yes	No
In the past year have you used an illegal drug or used a prescription medication for non-medical reasons?	○	○

Please answer the questions below, rating yourself on each of the criteria shown using the scale provided. As you answer each question, select the option that best describes how you have felt and conducted yourself over the past 6 months.

	Never	Rarely	Sometimes	Often	Very Often
How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?	○	○	○	○	○
How often do you have difficulty getting things in order when you have to do a task that requires organization?	○	○	○	○	○
How often do you have problems remembering appointments or obligations?	○	○	○	○	○
When you have a task that requires a lot of thought, how often do you avoid or delay getting started?	○	○	○	○	○
How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?	○	○	○	○	○
How often do you feel overly active and compelled to do things, like you were driven by a motor?	○	○	○	○	○

The questions listed below relate to your thoughts and feelings. If the way you have been in recent weeks or months differs from the way you usually are, please answer based on when you were your usual self.

	Yes	No
Do you find that most people will take advantage of you if you let them know too much about you?	○	○
Do you generally feel nervous or anxious around people?	○	○
Do you avoid situations where you have to meet new people?	○	○
Do you avoid getting to know people because you're worried that they may not like you?	○	○
Has avoidance of getting to know people due to fear of being disliked affected the number of friends that you have?	○	○

	Yes	No
Do you keep changing the way you present yourself to people because you don't know who you really are?	○	○
Do you often feel like your beliefs change so much that you don't know what you really believe any more?	○	○
Do you often get angry or irritated because people don't recognize your special talents or achievements as much as they should?	○	○

	Yes	No
Have you had any unusual experiences such as hearing voices, seeing visions, or having ideas you later found out were not true?	○	○
Have you had any other experiences, such as mind reading, ESP, thoughts being controlled by others, seeing things on TV that refer to you specifically?	○	○

CAGE-AID Questionnaire

When thinking about drug use, include illegal drug use and the use of prescription drug use other than prescribed.

Questions:	YES	NO
1. Have you ever felt that you ought to cut down on your drinking or drug use?	○	○
2. Have people annoyed you by criticizing your drinking or drug use?	○	○
3. Have you ever felt bad or guilty about your drinking or drug use?	○	○
4. 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?	○	○

Clinical History Form (1 / 16)

Stressors

Instruction: If you are filling this out on behalf of the patient, please answer from the patient's perspective.

Given the list of categories below, how much stress is each currently causing you?

	None	Mild Stress	Moderate Stress	Severe Stress
Family	○	○	○	○
Friends	○	○	○	○
Relationships	○	○	○	○
Educational	○	○	○	○
Economic	○	○	○	○
Occupational	○	○	○	○
Housing	○	○	○	○
Legal	○	○	○	○
Health	○	○	○	○

Substance Abuse History

Instruction: If you are filling this out on behalf of the patient, please answer from the patient's perspective.

Do you have a history of any recreational drug use?

- ○ Yes
- ○ No

If YES, please fill out the table below to the best of your knowledge:

Substance(s) Used:	YES	NO	Age of First Use	Age of Last Use	Amount per day	Days per month
Amphetamines / Speed	○	○				
Barbiturates / Downers	○	○				
Opiates	○	○				
Cocaine	○	○				
Psychedelics (e.g. LSD, Ecstasy, bath salts)	○	○				
Inhalants (e.g. glue, aerosols)	○	○				
Cannabis / Marijuana / Hashish	○	○				
Benzodiazepines	○	○				
PCP	○	○				

Substance Abuse Treatment History

Instruction: If you are filling this out on behalf of the patient, please answer from the patient's perspective.

Did you receive any treatment for substance abuse?

- ◯ Yes
- ◯ No

If YES, please fill out the table below to the best of your knowledge:

Treatment Type	YES	NO	How many episodes of treatment?	Age of first treatment?	Age of last treatment?	Any additional treatment information?
Inpatient	◯	◯				
Intensive Outpatient	◯	◯				
Outpatient	◯	◯				
12-Step Program	◯	◯				
Other						

Consequences of Substance Abuse

Instruction: If you are filling this out on behalf of the patient, please answer from the patient's perspective.

Have you experienced any of these consequences as a result of alcohol consumption or abuse of substances? (Please check all that apply)

- ☐ No consequences

- ☐ Felt that you needed to cut down on your drinking
- ☐ Been annoyed by others criticizing your drinking
- ☐ Felt guilty about drinking
- ☐ Needing a drink first thing in the morning

- ☐ Increased tolerance
- ☐ Withdrawal (shakes, sweating, nausea, rapid heart rate)
- ☐ Seizures
- ☐ Blackouts

- ☐ Effects on physical health
- ☐ Using/consuming more than intended
- ☐ Unintentional overdose
- ☐ DUI
- ☐ Arrests
- ☐ Physical fights or assaults
- ☐ Relationship conflicts
- ☐ Problems with money
- ☐ Job loss or problems at work/school

Other:

Inpatient Psychiatric History

Instruction: If you are filling this out on behalf of the patient, please answer from the patient's perspective.
Do you have a history of inpatient psychiatric treatment?

◯ Yes ◯ No

Please list any past inpatient treatment history below. Start with most recent and list each episode of treatment as a separate line.

Hospital/Facility	Treatment Voluntary?	Primary reason for hospitaliztion	How old were you?	Treatment Outcome	Additional Comments
		◯ Depression ◯ Suicidal Thoughts ◯ Suicide Attempt ◯ Manic Episode ◯ Psychotic Episode ◯ Severe Anxiety ◯ Drug/Alcohol Related ◯ Assault ◯ Violence		◯ Feeling Worse/ Negative Result ◯ Minor improvement / No effect ◯ Partial response ◯ Significant improvement ◯ Resolved / nearly Resolved problem	

Hospital/Facility	Treatment Voluntary?	Primary reason for hospitaliztion	How old were you?	Treatment Outcome	Additional Comments
		◯ Depression ◯ Suicidal Thoughts ◯ Suicide Attempt ◯ Manic Episode ◯ Psychotic Episode ◯ Severe Anxiety ◯ Drug/Alcohol Related ◯ Assault ◯ Violence		◯ Feeling Worse/ Negative Result ◯ Minor improvement / No effect ◯ Partial response ◯ Significant improvement ◯ Resolved / nearly Resolved problem	

Outpatient Psychiatric History

Instruction: If you are filling this out on behalf of the patient, please answer from the patient's perspective.

Do you have a history of outpatient psychiatric treatment?

- ○ Yes
- ○ No

Please list any past outpatient treatment history below. Start with most recent and list each episode of treatment as a separate line.

Provider	Primary reason for seeking treatment	Age of first treatment	Age of last treatment	Outcome

Suicide/Self-Harm History

Instruction: If you are filling this out on behalf of the patient, please answer from the patient's perspective.
Have you ever tried to harm or kill yourself?

Yes No

If you answered "no," skip the rest of this page and click "Next Section" at the bottom.

Was your intent to die?

Yes No

Elaborate below, if desired:

How many times in your life has this occurred?

Most Severe Episode

Please describe your most severe episode including date, method, and consequences:

Month: Year:

Method: Consequences:

Most Recent Episode

Please describe your most recent episode including date, method, and consequences:

Month: Year:

Method: Consequences:

Violence History Assessment

Instruction: If you are filling this out on behalf of the patient, please answer from the patient's perspective.

Have you had any history of violent behavior?

- Yes
- No

If YES, please elaborate below:

Past Medical History

Instruction: If you are filling this out on behalf of the patient, please answer from the patient's perspective.

Who is your primary care physician?

Are you taking any medications currently? (Excluding medications for psychiatric treatment)

- ○ Yes
- ○ No

If YES, please include these medications below:

Have you a history of any of the following health problems? (Please check all that apply)

- ☐ No Problems
- ☐ Allergies
- ☐ Anemia (low blood count)
- ☐ Arthritis
- ☐ Asthma
- ☐ Back problems (including disk or spine)
- ☐ Cancer
- ☐ Cataracts
- ☐ Fibromyalgia
- ☐ Gall Bladder disease
- ☐ Gastritis or Ulcer
- ☐ Glaucoma
- ☐ Gout
- ☐ Hearing Loss
- ☐ Heart disease
- ☐ Heart defect from birth
- ☐ Heart valve problems
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Liver disease (other)
- ☐ Lupus
- ☐ Migraine Headaches
- ☐ Multiple Sclerosis
- ☐ Obesity / Overweight
- ☐ Parkinson's Disease
- ☐ Polyps

- ☐ Chickenpox (as a child)
- ☐ Chronic Bronchitis
- ☐ COPD (Emphysema)
- ☐ Diabetes
- ☐ Diverticulitis
- ☐ Fainting spells/ Passing out
- ☐ High cholesterol
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ Hernia
- ☐ HIV
- ☐ Hypertension (High blood pressure)
- ☐ Hypotension (Low blood pressure)
- ☐ Inflammatory Bowel Disease
- ☐ Iron deficiency
- ☐ Seizures
- ☐ Sexually Transmitted Disease (STD)
- ☐ Sleep apnea
- ☐ Stroke/TIA
- ☐ Testosterone (low)
- ☐ Thyroid problems (hypothyroid/hyperthyroid)
- ☐ Tuberculosis or exposure to tuberculosis

Other:

Have you a history of surgery in any of the following areas? (Please check all that apply)

- ☐ No surgical history
- ☐ Back/Neck
- ☐ Brain
- ☐ Cardiac
- ☐ Ear/Nose/Throat
- ☐ Gall Bladder
- ☐ Hernia
- ☐ Hip/Knee/Ankle/Foot
- ☐ Hysterectomy (Ovaries Removed)
- ☐ Hysterectomy (Ovaries Retained)
- ☐ Intestine
- ☐ Kidney
- ☐ Liver
- ☐ Lung
- ☐ Pancreas
- ☐ Pelvis
- ☐ Prostate
- ☐ Sex Change
- ☐ Shoulder/Elbow/Wrist/Hand
- ☐ Stomach
- ☐ Tonsils
- ☐ Vagina
- ☐ Weight Loss

Psychiatric Medication History

Instruction: If you are filling this out on behalf of the patient, please answer from the patient's perspective.

Have you ever taken any medication for psychiatric treatment?

- ○ Yes
- ○ No

If YES, please fill out the table below to the best of your knowledge:

Medication name	Dose	How long? (months)	End Date	Therapeutic effect	Side Effects	Reason for stopping?

Patient Allergies

Instruction: If you are filling this out on behalf of the patient, please answer from the patient's perspective.

Do you have any known allergies to medication?

- ○ Yes
- ○ No

If YES, please fill out your allergy information below:

Medication Allergy	Allergic Reaction

Family History

Instruction: If you are filling this out on behalf of the patient, please answer from the patient's perspective.

Family Psychiatric History

Do you have any family members with a history of psychiatric illness?

○ Yes ○ No

If YES, please elaborate below using the following options:
Family Member: Mother, Father, Grandmother, Grandfather, Sister, Brother, Daughter, Son, Aunt, Uncle, Cousin

Psychiatric Problem(s): Depression, Panic Disorder, Generalized Anxiety Disorder, Social Anxiety Disorder, Obsessive Compulsive Disorder, Post Traumatic Stress Disorder, Bipolar Disorder, Eating Disorder, Alcoholism, Drug Abuse, ADHD, Personality Disorder, Schizophrenia / Psychosis, Psychiatric Hospitalization, Suicide Attempt, Suicide

Family Member: _____ **Psychiatric Problem(s):** _____

Family Member: _____ **Psychiatric Problem(s):** _____

Family Member: _____ **Psychiatric Problem(s):** _____

Family Member: _____ **Psychiatric Problem(s):** _____

Family Member: _____ **Psychiatric Problem(s):** _____

Family Member: _____ **Psychiatric Problem(s):** _____

Family Medical History

Is there any additional family medical history?

Developmental and Educational History

Instruction: If you are filling this out on behalf of the patient, please answer from the patient's perspective.

During your pregnancy/birth, did your mother have any problems with any of the following:

- [ ] None of these
- [ ] Exposure to drugs or alcohol during pregnancy
- [ ] A difficult pregnancy
- [ ] Problems with delivery

Other:

Did you have any complications after your birth? (e.g. premature birth, jaundice, breathing difficulties)

- ○ Yes
- ○ No

Did you have any delays or difficulties in reaching the following developmental milestones?

- [ ] None of these
- [ ] Walking
- [ ] Talking
- [ ] Toilet training
- [ ] Sleeping alone
- [ ] Being away from parents
- [ ] Making friends

Other:

Which options below best describe your childhood home atmosphere?

- ☐ Normal
- ☐ Supportive
- ☐ Parental fighting
- ☐ Parental violence
- ☐ Financial difficulties
- ☐ Frequent moving

Other:

Which of the following challenges were experienced during your childhood?

- ☐ None of these
- ☐ Tantrums
- ☐ Enuresis (bed wetting)
- ☐ Encopresis (fecal incontinence)
- ☐ Running away from home
- ☐ Fighting
- ☐ Stealing
- ☐ Property damage
- ☐ Fire setting
- ☐ Animal cruelty
- ☐ Separation anxiety
- ☐ Victim of bullying
- ☐ Engaged in bullying
- ☐ Depression
- ☐ Death of a parent/caregiver
- ☐ Parental divorce

Which of the following best describe problems you may have had in school?

- ☐ None of these
- ☐ Fighting
- ☐ School phobia
- ☐ Truancy
- ☐ Detentions
- ☐ Suspensions
- ☐ Expulsions
- ☐ School refusal
- ☐ Class failures
- ☐ Repetition of grades
- ☐ Special education
- ☐ Remedial classes

Did you have additional schooling outside of the standard classroom setting? (please check all that apply)

- ☐ None of these
- ☐ Speech classes
- ☐ Tutoring
- ☐ Accommodations

Other:

Please select your highest Level of Education:

- ☐ Less than a high school diploma
- ☐ High school graduates, no college
- ☐ Some college or associate degree
- ☐ Bachelor's degree and higher

If you have any further comments about your developmental or educational history and wish to elaborate further, please do so in the space provided below:

General Social History

Instruction: If you are filling this out on behalf of the patient, please answer from the patient's perspective.

Which options below best describes your social situation?

- ☐ Supportive social network
- ☐ Few friends
- ☐ Substance-use based friends
- ☐ No friends
- ☐ Distant from family of origin
- ☐ Family conflict

Other:

What is your current marital status?

- ☐ Single, never married
- ☐ Married / Permanent Partnership
- ☐ Divorced
- ☐ Separated or divorce in process
- ☐ Widowed

What is the status of your intimate relationship?

- ☐ Never been in a serious relationship
- ☐ Not currently in a relationship
- ☐ Currently in a serious relationship

What is the satisfaction level of your intimate relationship?

- ☐ Very satisfied
- ☐ Satisfied
- ☐ Somewhat satisfied
- ☐ Dissatisfied
- ☐ Not applicable

What is your sexual orientation?

- ☐ Heterosexual
- ☐ Homosexual
- ☐ Bisexual

What is your current living situation?

- ☐ Rent (apartment / house)
- ☐ Own (house / condo)
- ☐ Group Home
- ☐ Homeless
- ☐ Foster care

Who do you currently live with? (Please check all that apply)

- ☐ Live alone
- ☐ Roommates
- ☐ Partner/Spouse
- ☐ Parent(s)
- ☐ Sibling(s)
- ☐ Children

Other:

Do you currently participate in spiritual activities?

- ☐ Yes
- ☐ No

What is your current occupation status?

- ☐ Employed full time
- ☐ Employed part time
- ☐ Temp / Seasonal employment
- ☐ Full time student
- ☐ Part time student
- ☐ Homemaker
- ☐ Unemployed (seeking work)
- ☐ Unemployed (not seeking work)
- ☐ Retired
- ☐ Disability

What is your current yearly income?

- ☐ Less than $11,000
- ☐ $11,001 - $25,999
- ☐ $26,000 - $75,999
- ☐ $76,000 - $100,000
- ☐ More than $100,000

What is your longest period of continuous employment? (Please include dates and description)

Employment start: Employment end:

_____ _____

Description:

_____

What is your longest period of continuous unemployment? (Please include dates and description)

Unemployment start: Unemployment end:

_____ _____

Description:

_____

Menstruation and Pregnancy History

Instruction: If you are filling this out on behalf of the patient, please answer from the patient's perspective.

At what age did you begin menstruation? _____

Which of these best describe your premenstrual symptoms?

- ☐ None of these
- ☐ Dysphoria
- ☐ Cramps
- ☐ Appetite change
- ☐ Bloating
- ☐ Sleep disturbance

Do you have a method of contraception? (check all that apply)

- ☐ No method of contraception
- ☐ Intrauterine (e.g., IUD)
- ☐ Hormonal (e.g., implant, injection, "the pill," patch, hormonal vaginal contraceptive ring)
- ☐ Barrier (e.g., diaphragm, male/female condom, spermicide)
- ☐ Fertility Awareness-based (e.g., natural family planning)
- ☐ Permanent (e.g., male/female sterilization, infertility)
- ☐ Other:

Have you ever been pregnant?	◯ Yes	◯ No	If YES, how many times? _____
Have you ever given birth?	◯ Yes	◯ No	If YES, how many times? _____
Have you had any miscarriages?	◯ Yes	◯ No	If YES, how many times? _____
Have you had any abortions?	◯ Yes	◯ No	If YES, how many times? _____

Review of Systems

Please look at the list of physical symptoms below and check off any that you have experienced in the last several days. If you have NOT experienced any symptoms in an area, be sure to check "None of the above" for that area. If you are filling this out on behalf of the patient, please answer from the patient's perspective.

Constitutional

- ☐ Chronic pain
- ☐ Loss of appetite
- ☐ Increase in appetite
- ☐ Unexplained weight loss
- ☐ Weight gain
- ☐ Fatigue/Lethargy
- ☐ Unexplained fever
- ☐ Hot or Cold spells
- ☐ Night sweats
- ☐ Sleeping pattern disruption
- ☐ Malaise (Flu-like or Vague sick feeling)

Other:

- ☐ None of the above constitutional issues

Eyes

- ☐ Eye pain
- ☐ Eye discharge
- ☐ Eye redness
- ☐ Blurred or double vision
- ☐ Visual change
- ☐ History of eye surgery
- ☐ Sensitivity to light
- ☐ Scotomas (Blind spots)
- ☐ Retinal hemorrhage (Floaters in vision)
- ☐ Amaurosis fugax (Feeling like a curtain is pulled over vision)

Other:

- ☐ None of the above eye issues

Ears, Nose, Mouth, and Throat

- ☐ Earache
- ☐ Tinnitus (Ringing in ears)
- ☐ Decreased hearing or hearing loss
- ☐ Frequent ear infections
- ☐ Frequent nose bleeds
- ☐ Sinus congestion
- ☐ Runny nose/Post-nasal drip
- ☐ Difficulty swallowing
- ☐ Frequent sore throat
- ☐ Prolonged hoarseness
- ☐ Pain in jaw or tooth
- ☐ Dry mouth

Other:

- ☐ None of the above ear, nose, mouth or throat issues

Cardiovascular

- ☐ Chest pain
- ☐ Pacemaker
- ☐ Palpitations (fast or irregular heartbeat)
- ☐ Swollen feet or hands
- ☐ Fainting spells
- ☐ Shortness of breath with exercise

Other: _____

- ☐ None of the above cardiovascular issues

Respiratory

- ☐ Pain with breathing
- ☐ Chronic cough
- ☐ Chronic shortness of breath
- ☐ Chronic wheezing/Asthma
- ☐ Excessive phlegm
- ☐ Coughing blood
- ☐ Nocturnal Dyspnea (Shortness of breath at night)

Other: _____

- ☐ None of the above respiratory issues

Musculoskeletal

- ☐ Swelling in joints
- ☐ Redness of joints
- ☐ Other joint pains or stiffness
- ☐ Muscle pain or cramping
- ☐ Muscle weakness
- ☐ Muscle stiffness
- ☐ Decreased range of motion
- ☐ Back pain or stiffness
- ☐ History of fractures
- ☐ Past injury to spine or joints

Other: _____

- ☐ None of the above musculoskeletal issues

Gastrointestinal

- ☐ Excessive flatulence or belching
- ☐ Diarrhea
- ☐ Constipation
- ☐ Persistent nausea/vomiting
- ☐ Abdominal Pain
- ☐ Heartburn
- ☐ Difficulty swallowing solids or liquids
- ☐ Recent loss in appetite
- ☐ Sensitivity to milk products
- ☐ Jaundice (yellow skin)
- ☐ Change in appearance of stool
- ☐ Blood in stool
- ☐ Dark/Tarry stool
- ☐ Loss of bowel control/soiling

Other: _____

☐ None of the above gastrointestinal issues

Allergic/Immunologic

- ☐ Frequent infections
- ☐ Hives
- ☐ Anaphylaxic reaction

Other: _____

☐ None of the above allergic or immunologic issues

Endocrine

- ☐ Severe menopausal symptoms
- ☐ Cold or heat intolerance
- ☐ Excessive appetite
- ☐ Excessive thirst or urination
- ☐ Excessive sweating

Other: _____

☐ None of the above endocrine issues

Hematologic/Lymphatic

- ☐ Blood clots
- ☐ Excess/easy bleeding (surgery, dental work, brushing teeth, scrapes)
- ☐ History of blood transfusion
- ☐ Excessive bruising
- ☐ Swollen glands (neck, armpits, groin)

Other: _____

☐ None of the above hematologic or lymphatic issues

Genitourinary (General)

- ☐ Loss of urine control (including bed-wetting)
- ☐ Painful/Burning urination
- ☐ Blood in urine
- ☐ Increased frequency of urination
- ☐ Up more than twice/night to urinate
- ☐ Urine retention
- ☐ Frequent urine infections

Other: _____

☐ None of the above general genitourinary issues

Genitourinary (Women)

- ☐ Unusual vaginal discharge
- ☐ Vaginal pain, bleeding, soreness, or dryness
- ☐ Genital sores
- ☐ Heavy or irregular periods
- ☐ No menses (Periods stopped)
- ☐ Currently pregnant
- ☐ Sterility/Infertility
- ☐ Any other sexual or sex organ concerns

Other: _____

☐ None of the above sex-specific genitourinary issues

Genitourinary (Men)

- ☐ Slow urine stream
- ☐ Scrotal pain
- ☐ Lump or mass in the testicles
- ☐ Abnormal penis discharge
- ☐ Trouble getting/maintaining erections
- ☐ Inability to ejaculate/orgasm
- ☐ Any other sexual or sex organ concerns

Other: _____

☐ None of the above sex-specific genitourinary issues

Neurological

- ☐ Paralysis
- ☐ Fainting spells or blackouts
- ☐ Dizziness/Vertigo
- ☐ Drowsiness
- ☐ Slurred speech
- ☐ Speech problems (other)
- ☐ Short term memory trouble
- ☐ Memory difficulties (loss)
- ☐ Frequent headaches
- ☐ Muscle weakness
- ☐ Numbness/Tingling sensations
- ☐ Neuropathy (numbness in feet)
- ☐ Tremor in hands/shaking
- ☐ Muscle spasms or tremors

Other: ☐

☐ None of the above neurological issues

Integumentary (Skin/Breast and Hair)

- ☐ Lesions
- ☐ Unusual mole
- ☐ Easy bruising
- ☐ Increased perspiration
- ☐ Rashes
- ☐ Chronic dry skin
- ☐ Itchy skin or scalp
- ☐ Hair or nail changes
- ☐ Hair loss
- ☐ Breast tenderness
- ☐ Breast discharge
- ☐ Breast lump or mass

Other: ☐

☐ None of the above integumentary issues

Psychiatric

- ☐ In-depth review of psychiatric system appears earlier in document (to be checked by clinician only)
- ☐ Feeling depressed
- ☐ Difficulty concentrating
- ☐ Phobias/Unexplained fears
- ☐ No pleasure from life anymore
- ☐ Anxiety
- ☐ Insomnia
- ☐ Excessive moodiness
- ☐ Stress
- ☐ Disturbing thoughts
- ☐ Manic episodes
- ☐ Confusion
- ☐ Memory loss
- ☐ Nightmares

Other: ☐

☐ None of the above psychiatric issues

GAD-7

Please read each statement and select a number 0, 1, 2 or 3 which indicates how much the statement applied to you over the past two weeks. There are no right or wrong answers. Do not spend too much time on any one statement. This assessment is not intended to be a diagnosis. If you are concerned about your results in any way, please speak with a qualified health professional.

	0: Not at all	1: Several days	2: More than half the days	3: Nearly every day
Feeling nervous, anxious or on edge	○	○	○	○
Not being able to stop or control worrying	○	○	○	○
Worrying too much about different things	○	○	○	○
Trouble relaxing	○	○	○	○
Being so restless that it is hard to sit still	○	○	○	○
Becoming easily annoyed or irritable	○	○	○	○
Feeling afraid as if something awful might happen	○	○	○	○

Patient Health Questionnaire (PHQ)

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	○	○	○	○
2. Feeling down, depressed, or hopeless	○	○	○	○
3. Trouble falling or staying asleep, or sleeping too much	○	○	○	○
4. Feeling tired or having little energy	○	○	○	○
5. Poor appetite or overeating	○	○	○	○
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	○	○	○	○
7. Trouble concentrating on things, such as reading the newspaper or watching television	○	○	○	○
8. Moving or speaking so slowly that other people could have noticed. Or the opposite- being so fidgety or restless that you have been moving around a lot more than usual	○	○	○	○
9. Thoughts that you would be better off dead, or of hurting yourself in some way	○	○	○	○

WHODAS 2.0

This questionnaire asks about difficulties due to health/mental health conditions. Health conditions include diseases or illnesses, other health problems that may be short or long lasting, injuries, mental or emotional problems, and problems with alcohol or drugs.

Think back over the past 30 days and answer these questions, thinking about how much difficulty you had doing the following activities. For each question, please mark only one response.

In the past 30 days, how much difficulty did you have in:

Understanding and communicating	**None**	**Mild**	**Moderate**	**Severe**	**Extreme / cannot do**
D1.1 Concentrating on doing something for ten minutes?	○	○	○	○	○
D1.2 Remembering to do important things?	○	○	○	○	○
D1.3 Analyzing and finding solutions to problems in day-to-day life?	○	○	○	○	○
D1.4 Learning a new task, for example, learning how to get to a new place?	○	○	○	○	○
D1.5 Generally understanding what people say?	○	○	○	○	○
D1.6 Starting and maintaining a conversation?	○	○	○	○	○

In the past 30 days, how much difficulty did you have in:

Getting around	**None**	**Mild**	**Moderate**	**Severe**	**Extreme / cannot do**
D2.1 Standing for long periods such as 30 minutes?	○	○	○	○	○
D2.2 Standing up from sitting down?	○	○	○	○	○
D2.3 Moving around inside your home?	○	○	○	○	○
D2.4 Getting out of your home?	○	○	○	○	○
D2.5 Walking a long distance such as a mile [or equivalent]?	○	○	○	○	○

In the past 30 days, how much difficulty did you have in:

Self-care	None	Mild	Moderate	Severe	Extreme or cannot do
D3.1 Washing your whole body?	○	○	○	○	○
D3.2 Getting dressed?	○	○	○	○	○
D3.3 Eating?	○	○	○	○	○
D3.4 Staying by yourself for a few days?	○	○	○	○	○

In the past 30 days, how much difficulty did you have in:

Getting along with people	None	Mild	Moderate	Severe	Extreme or cannot do
D4.1 Dealing with people you do not know?	○	○	○	○	○
D4.2 Maintaining a friendship?	○	○	○	○	○
D4.3 Getting along with people who are close to you?	○	○	○	○	○
D4.4 Making new friends?	○	○	○	○	○
D4.5 Sexual activities?	○	○	○	○	○

In the past 30 days, how much difficulty did you have in:

Life activities	None	Mild	Moderate	Severe	Extreme or cannot do
D5.1 Taking care of your household responsibilities?	○	○	○	○	○
D5.2 Doing most important household tasks well?	○	○	○	○	○
D5.3 Getting all the household work done that you needed to do?	○	○	○	○	○
D5.4 Getting your household work done as quickly as needed?	○	○	○	○	○

If you work (paid, non-paid, self-employed) or go to school, complete questions D5.5–D5.8, below. Otherwise, skip to D6.1.

Because of your health condition, in the past 30 days, how much difficulty did you have in:	None	Mild	Moderate	Severe	Extreme or cannot do
D5.5 Your day-to-day work/school?	○	○	○	○	○
D5.6 Doing your most important work/school tasks well?	○	○	○	○	○
D5.7 Getting all the work done that you need to do?	○	○	○	○	○
D5.8 Getting your work done as quickly as needed?	○	○	○	○	○

Participation in society. In the past 30 days:	None	Mild	Moderate	Severe	Extreme or cannot do
D6.1 How much of a problem did you have in joining in community activities (for example, festivities, religious or other activities) in the same way as anyone else can?	○	○	○	○	○
D6.2 How much of a problem did you have because of barriers or hindrances in the world around you?	○	○	○	○	○
D6.3 How much of a problem did you have living with dignity because of the attitudes and actions of others?	○	○	○	○	○

Participation in society. In the past 30 days:	None	Some	Moderate	A Lot	Extreme or cannot do
D6.4 How much time did you spend on your health condition, or its consequences?	○	○	○	○	○

Participation in society. In the past 30 days:	None	Mild	Moderate	Severe	Extreme or cannot do
D6.5 How much have you been emotionally affected by your health condition?	○	○	○	○	○
D6.6 How much has your health been a drain on the financial resources of you or your family?	○	○	○	○	○

Participation in society. In the past 30 days:	None	Mild	Moderate	Severe	Extreme or cannot do
D6.7 How much of a problem did your family have because of your health problems?	○	○	○	○	○
D6.8 How much of a problem did you have in doing things by yourself for relaxation or pleasure?	○	○	○	○	○

H1. Overall, in the past 30 days, how many days were these difficulties present? Record number of days:

H2. In the past 30 days, for how many days were you totally unable to carry out your usual activities or work because of any health condition? Record number of days:

H3. In the past 30 days, not counting the days that you were totally unable, for how many days did you cut back or reduce your usual activities or work because of any health condition? Record number of days:

I have completed, or had completed on my behalf, this questionnaire to the best of my ability. This information is true and correct, and can be used in conducting my Diagnostic Assessment.

Patient Signature

Date