Fireweed Health Care, Inc.

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NEW PATIENT PSYCHIATRIC VISIT QUESTIONNAIRE

PERSONAL AND FAMILY MEDICAL HISTORY

Name _____ Date _____

Referred by: _____

Primary Care Provider: _____

Heart: (*Please circle All that apply)*

Heart Attack	Arrhythmia	Palpitations
Chest Pain	Pacemaker	Lightheadedness
High Blood Pressure	Heart Murmur	Other:

Lungs: (*Please circle All that apply)*

Asthma	COPD	Emphysema
Sleep Apnea	Supplemental Oxygen	Other:

Neurological: (*Please circle All that apply)*

Seizures	Traumatic Brain Injury	Headache Disorder
Stroke	Tremors	Other:

GI/GU: (*Please circle All that apply)*

Hepatitis C	Hepatitis B	Hepatitis A
Stomach or other GI Disorder including ulcers	GERD/Heartburn	Cirrhosis of the Liver
Chronic Kidney Disease	Dialysis	Other:

Endocrine: (*Please circle All that apply)*

Diabetes	Thyroid Disorder	Other:

Hematological/Lymphatic: (*Please circle All that apply)*

Anemia	Sickle Cell Disease	Bleeding Disorder
Clotting Disorder	Cancer	Other:

Musculoskeletal: (*Please circle All that apply)*

Arthritis	Rheumatoid Arthritis	Fibromyalgia
Injury	Other:	

Chronic Pain Issues (*Describe):* _____

Infectious: (*Please circle All that apply)*

NIV/AIDS	Endocarditis	Osteomyelitis
MRSA	Syphilis	Tuberculosis

Sexual Health: (*Please circle All that apply)*

Not Sexually Active	Condoms	Hysterectomy
Tubal Ligation (tubes tied)	Depo Shot	Nexplanon
IUD	Contraceptive Pill	Other:

Are you, or could you become pregnant? Yes / No

Date of Last Menstrual Cycle:

_____

*****PLEASE NOTIFY FHC IF YOU BECOME PREGNANT so we can arrange the very best continuing care for you. *****

Are your sexual partners men, women, or both? _____

Have you recently tested positive for any STIs? Yes / No

If yes, did you and your partner(s) receive appropriate treatment? Yes / No

When was the last time you saw your primary care provider? _____

Current Medications

Please list all medications with doses that you are currently taking, including OTC, herbal, and supplements.

Allergies:

Please list all known allergies, reactions, and severity (*Mild, Moderate, Severe*).

1._____

2. _____

3. _____

Surgeries and Hospitalizations

Please list all hospitalizations and/or surgeries that you have ever had. Please list the date and reasons for care.

Surgeries and Hospitalizations	Name of Hospital	Date:
1.		
2.		
3.		
4.		

MENTAL HEALTH HISTORY (*Please circle all that apply & list treatment)*

ADD/ADHD Treatment:	OCD Treatment:	Bipolar Disorder Treatment:
Schizophrenia Treatment:	Depression Treatment:	Anxiety Treatment:
PTSD Treatment:	Eating Disorder Treatment:	Personality Disorder Treatment:
Hallucinations (Auditory, Visual, Other) Treatment:	Personality Disorder Treatment:	Other Treatment:

Do you have any thoughts of suicide or of wanting to hurt yourself or others? Yes/No

If yes, do you have a plan? Yes / No

If yes, please describe_____

_____

Have you ever attempted suicide in the past? Yes / No If yes, please state when & what method did you use? _____

_____

Mental Health Care & Counseling

Please circle any type of counseling you are currently engaged in or have tried in the past. Please include name(s) and year(s) of participation

Inpatient Psychiatric	Outpatient Psychiatric
1:1 Counseling	Spiritual Leader (priest, pastor, bishop etc)
Other:	Other:

SOCIAL AND OCCUPATIONAL HISTORY: *(Please circle All that apply)*

Are you? Married Divorced Separated Single

Do you have children? Yes / No **If yes,** do they live with you? Yes / No

Please list ages and sex of your children:

_____ _____

_____ _____

Housing Status: (*Please circle all answers that apply*)

Homeless	Own Home	Rent	Inpatient Treatment
Couch Surfing	Stable	Unstable	Other:

Who do you live with? (Please circle all answers that apply)

Alone	Spouse	Children	Friend(s)
Parent(s)	Shelter	Inpatient Treatment	Other:

Do you feel safe at home? Yes / No If not, what would it take to feel safe? _____

_____

Social Support

Do you have supportive relationships with family and friends?

Education/Job Training (Please circle all answers that apply)

GED H.S. Diploma Some College College Graduate Trade School Apprenticeship

Other _____

Are you interested in pursuing additional training and /or education? Yes / No

Employment Status: (Please circle all answers that apply)

Full-Time	Part-Time	Unemployed	Slope Worker
Seasonal Work	Stable	Unstable	Other:

If employed, please state employer: _____

F**inancial Status:** (*Please circle all answers that apply*)

I feel financially stable Having financial problems Receiving Assistance Family helpsNo source of income Friends help Other: _____

SUBSTANCE USE HISTORY

What substances do you use? (*Please include current and past substance use & tobacco*)

Name of Substance?	**Age of Of First Use?**	**How often Used? (i.e. daily)**	**Amount (How much?)**	**Route (i.e. by mouth, Snorting injection)**	**Last use? (Day, Month, Year)**

Have you ever received treatment for substance use? If yes, in what setting? (*see below*)

Please circle any type of treatment you have tried and write the name of the program including the year(s) of treatment.

Setting	**Name of Program**	**Completed Yes/No**	**Month & Year**
Inpatient			
Outpatient			
Residential Care			
12-Step Group			

CAGE-AID Questionnaire

When thinking about drug or alcohol use, include illegal drug use and the use of prescription drug use other than prescribed. **At any time in your life, have you:**

Have you ever felt that 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 (**eye-opener**)?	▢ Yes ▢ No

Generalized Anxiety Disorder (GAD-7) Questionnaire

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge.	▢	▢	▢	▢
2. Not being able to stop or control worrying.	▢	▢	▢	▢
3. Worrying too much about different things.	▢	▢	▢	▢
4. Trouble relaxing.	▢	▢	▢	▢
5. Being so restless that it's hard to sit still.	▢	▢	▢	▢
6. Becoming easily annoyed or irritable.	▢	▢	▢	▢
7. Feeling afraid as if something awful might happen.	▢	▢	▢	▢
	XXXXXX			
Total Score	XXXXXX	XXXXXX	XXXXXX	

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____ Somewhat difficult _____ Very difficult _____ Extremely difficult _____

Patient Health Questionnaire (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (circle your response)	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.	▢	▢	▢	▢
	XXXXX			
Total	XXXXX	XXXXX	XXXXX	

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____ Somewhat difficult _____ Very difficult _____ Extremely difficult _____

Mood Disorder Questionnaire (MDQ)

Please answer each question to the best of your ability:

1. Has there ever been a period 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-confidence than usual?		
…You got much less sleep than usual and found that you didn't' really miss it?		
…You were more talkative or spoke much faster than usual?		
…Thoughts raced through your head or you could not slow your mind down?		
…You were so easily distracted by things around you that you had trouble concentrating or staying on track?		
…You had 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		
…Spending money got you or your family in trouble?		

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 a family, money, or legal troubles; getting into arguments or fights?	No Problem	Minor Problem	Moderate Problem	Serious Problem
	☐	☐	☐	☐

GOALS *(Please list specific goals you plan to work on in your therapy sessions & how you plan to achieve them).*

1. **_____**
   a. Plan:

2. **_____**
   b. Plan:

3. **_____**
   c. Plan:

Which pharmacy will you be using? _____

REVIEW OF SYSTEMS (Check the box of all symptoms you have been experiencing since your last visit.)

Constitutional:
- ▢ Fatigue
- ▢ Restlessness
- ▢ Fever
- ▢ Chills
- ▢ Weight loss
- ▢ Cold flushes
- ▢ Night sweats
- ▢ Weakness
- ▢ Increased appetite
- ▢ Decreased appetite
- ▢ Weight gain
- ▢ Headache
- ▢ Hot flashes

Skin:
- ▢ Rash
- ▢ Hives
- ▢ Sweating
- ▢ Excessive itching
- ▢ Moles changing size, shape or color
- ▢ Sores
- ▢ Goosebumps
- ▢ Blisters
- ▢ Painful lesions

HEENT:
- ▢ Nasal congestion
- ▢ Watery eyes
- ▢ Sore throat
- ▢ Loss of teeth
- ▢ Visual changes
- ▢ Loss of taste
- ▢ Loss of smell
- ▢ Sore throat
- ▢ Dry mouth
- ▢ Runny nose
- ▢ Yawning
- ▢ Dentures
- ▢ Hearing loss
- ▢ Ringing in ears
- ▢ Dry mouth
- ▢ Cavities/gum disease

Cardiovascular:
- ▢ Chest pain
- ▢ Heart racing
- ▢ Lightheaded
- ▢ Palpitations
- ▢ High blood pressure
- ▢ Swollen ankles or legs

Respiratory:
- ▢ Shortness of breath
- ▢ Cough
- ▢ COPD/emphysema
- ▢ Wheezing
- ▢ Sleep Apnea

Musculoskeletal:
- ▢ Twitching
- ▢ Weakness
- ▢ Shaking
- ▢ General body aches
- ▢ Joint swelling
- ▢ Morning stiffness
- ▢ Bone aches
- ▢ Cramps
- ▢ Muscle aches
- ▢ Joint pain
- ▢ Joint redness

Genitourinary:
- ▢ Difficulty urinating
- ▢ Blood in urine
- ▢ Leaky bladder
- ▢ Loss of bladder control

If female: Are you pregnant? ▢ Yes ▢ No
Date of last cycle: _____
Please notify us immediately if you become pregnant.

Gastrointestinal:
- ▢ Nausea
- ▢ Diarrhea
- ▢ Heartburn
- ▢ Stomach cramps
- ▢ Loss of bowel control
- ▢ Abdominal pain, cramping or distension
- ▢ Vomiting
- ▢ Constipation
- ▢ Red blood in stool
- ▢ Black, tarry stool
- ▢ Yellow eyes or skin

Bowel Movements are:
- ▢ Daily
- ▢ Every other day
- ▢ 2x/week
- ▢ Every 5-6 days
- ▢ Once weekly

Is this your normal frequency? ▢ Yes ▢ No
Is this ▢ LESS or ▢ MORE frequent than normal?

Neurological:
- ▢ Tremors
- ▢ Tingling
- ▢ Fainting
- ▢ Frequent falls
- ▢ Headache
- ▢ Numbness
- ▢ Light headed
- ▢ Weakness
- ▢ Seizures
- ▢ Involuntary movements

Endocrine:
- ▢ Diabetes
- ▢ Excessive thirst
- ▢ Heat/Cold Intolerance
- ▢ Thyroid Issues
- ▢ Low libido

Hematologic/Lymphatic:
- ▢ Abnormal bleeding
- ▢ Swollen lymph nodes
- ▢ Anemia
- ▢ Bleeding disorder
- ▢ Bruising easily
- ▢ Lymphedema
- ▢ Clotting disorder

Immunologic/Allergic:
- ▢ Asthma
- ▢ Current cold
- ▢ Seasonal allergies
- ▢ Current flu

Psychiatric
- ▢ Suicidal thoughts
- ▢ Anxiety
- ▢ Depression
- ▢ Craving drugs
- ▢ Bi-polar disorder
- ▢ PTSD
- ▢ Hearing voices
- ▢ Irritability
- ▢ Changes in mood
- ▢ Homicidal thoughts
- ▢ Irritability
- ▢ Hallucinations
- ▢ Schizophrenia
- ▢ Panic attacks
- ▢ ADD/ADHD
- ▢ Anger
- ▢ OCD
- ▢ Difficulty sleeping