Dr. Lester Sandman

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NEW PATIENT HEALTH INFORMATION

The purpose of this questionnaire is to make the first visit more comprehensive as well as efficient. Please answer the following as completely as you can:

Date: _____

Name: _____

Age: _____ Date of Birth: _____

Referred by: _____

Reason for referral:_____

_____

_____

Your current mental health providers: Phone Numbers:

Primary care provider:

Any other health care providers?

CURRENT AND PAST MENTAL HEALTH TREATMENT

Please list any present or past psychiatric treatment, counseling, psychotherapy, family therapy or chemical dependency treatment:

Dates: **Clinician name & degree:** **Type of treatment:**

Have you ever been in a psychiatric or alcohol/drug rehabilitation hospital?

Dates: **Name of hospital/Clinic:** **Reason:**

Are you currently on or have you taken medications for a psychiatric or nervous condition in the past?

Date started: **Date stopped:** **Medication and dose:** **Result:**

Are you currently on any other medications for any other reason?

Allergies and medication reactions (please describe reaction):

PRESENTING PROBLEMS: **Please indicate if absent, mild, moderate, or severe? How long?**

sad or flat mood

slowed thinking

trouble making decisions

reduced enjoyment/interest

easy crying

low energy

decreased sex drive

social withdrawal

elevated or giddy mood

irritability

mind racing

impulsive decision-making

talking fast or a lot

excess energy/agitation

increased sex drive

anxiety

panic (time-limited, overwhelming)

compelled to do something repeatedly (checking locks, washing hands, etc.)

Hoarding, having difficulty throwing things away

hallucinations (hearing or seeing things that may not be there)

paranoid (feeling like others are watching or following you)

difficulty concentrating/focusing

suicidal thoughts/impulses/plans

suicide attempts - when, how

non-suicidal self-harm - when, how

thoughts of physically hurting others

acting violently toward others - when, how

vomiting or laxatives for weight loss

PAST & PRESENT SUBSTANCE USE

SUBSTANCE:	HOW OFTEN:	AMOUNT EACH USE:	LAST USE:
Caffeine			
Tobacco			
Sedatives and sleeping pills (Valium, Xanax, Klonopin, barbiturates, etc.)			
Alcohol (beer, wine, liquor)			
Marijuana			
Hallucinogens (LSD, mushrooms, etc.)			
cocaine (including crack)			
amphetamines			
Opioids, used more than prescribed (Morphine, heroin, codeine)			
Other substances used illegally or to get "high" or to come off a "high			

YES	NO	WHEN	
_____	_____	_____	Have you ever been cited for an alcohol or drug related offense?
_____	_____	_____	Have you ever felt bad or guilty about your alcohol or drug use?
_____	_____	_____	Have you ever cut back deliberately on your alcohol or drug use?
_____	_____	_____	Have you used alcohol or drugs in the morning?
_____	_____	_____	Have others annoyed you with their talk about your alcohol or drug use?
_____	_____	_____	Have you ever had a "blackout " from alcohol or drugs (not passing out)?

FAMILY HISTORY

Mental Illness in Family Were any blood relatives (e.g., parents, grandparents, siblings, aunts, uncles, children) treated with medications, counseling or hospitalizations for depression, anxiety, nerves, "nervous breakdown," alcohol problems, drug problems or any other psychiatric or psychological condition? Any suicides? Undiagnosed mental illness? Which side of the family?

Medical Illness in Family (diabetes, anemia, bleeding disorders, gout, arthritis, cancer, heart disease, high blood pressure, stroke, etc.):

MEDICAL HISTORY AND REVIEW OF SYSTEMS:

Please list all hospitalizations for medical (non-psychiatric) illness, injury or surgery:

Date	Hospital Name	Reason for hospitalization
_____	_____	_____
_____	_____	_____
_____	_____	_____

Review of Systems:

YES	NO	WHEN	
_____	_____	_____	Fainting or passing out
_____	_____	_____	Unexplained loss of body function
_____	_____	_____	Loss of the ability to use a body part
_____	_____	_____	Seizures
_____	_____	_____	Unexplained dizziness/vertigo in last year
_____	_____	_____	Change in sense of smell
_____	_____	_____	Unexplained trouble speaking
_____	_____	_____	Memory trouble that concerned you
_____	_____	_____	Blow to the head with any loss of consciousness or memory
_____	_____	_____	Unexplained loss of a period of time
_____	_____	_____	Smelling foul or burning odor that may not be there
_____	_____	_____	Told you have glaucoma
_____	_____	_____	Headaches not relieved with aspirin/Tylenol in last year
_____	_____	_____	Diagnosed with cancer
_____	_____	_____	Unexplained fever in last year
_____	_____	_____	Diagnosed with a heart problem
_____	_____	_____	Diagnosed with an artery or vein problem
_____	_____	_____	Diagnosis of a lung problem
_____	_____	_____	Told you snore heavily
_____	_____	_____	Diagnosed with a stomach, liver, intestine, or gallbladder problem
_____	_____	_____	Had jaundice (yellow skin)
_____	_____	_____	Diagnosed with a kidney or bladder problem
_____	_____	_____	Diagnosed with a sexually transmitted disease Type of disease:_____

_____ _____ _____ Told you have a bleeding or clotting disorder
_____ _____ _____ Told you have anemia
_____ _____ _____ Told you have a thyroid or other gland problem
_____ _____ _____ Noticed a change in your tolerance of heat or cold
_____ _____ _____ Told you have diabetes

_____ _____ _____ Unexplained darkening of skin
_____ _____ _____ Low blood pressure
_____ _____ _____ Weight gain ( ) loss ( ) How much_____
_____ _____ _____ Unexplained nausea & vomiting in last year
_____ _____ _____ Excessive fatigue & weakness in the last year
_____ _____ _____ High blood pressure
_____ _____ _____ Easy bruising in last year
_____ _____ _____ Skin thinning with purple marks (no bruises)
_____ _____ _____ Fracture in last 5 years
_____ _____ _____ Told you have osteoporosis

_____ _____ _____ Unexplained abdominal pain in the past year
_____ _____ _____ Regularly exposed to industrial toxins, (e.g., pesticides, mercury, Manganese, rubber and/or rayon solvent)

For women:

_____ _____ _____ Diagnosed with breast, uterine, cervical and/or ovary problem
_____ _____ _____ Hot flashes
_____ _____ _____ Used birth control pills in the last year
_____ _____ _____ Could be currently pregnant or wish to become pregnant soon

Current form of birth control:_____

FAMILY OF ORIGIN

Biological parents together until you were 18 years old?_____

Biological parents divorced? If so, when_____

Mother: Age _____Cause of death if deceased _____

Father: Age _____Cause of death if deceased_____

Number of siblings_____

TRAUMA HISTORY

Sexually or physically abused: ( ) Yes ( ) No If yes:

By whom _____

At what age _____

Experienced war or natural disaster: ( ) Yes ( ) No If yes:

Nature of experience _____

When _____

LEGAL HISTORY

(Arrests, convictions, imprisonment, probation, current legal problems)_____

_____

_____

_____

MILITARY HISTORY

Served in military: ( ) Yes ( ) No. If yes:

Currently: ( ) active duty ( ) reserve ( ) retired ( ) discharged

Highest rank _____

Disciplinary actions _____

Awards _____

EDUCATION

( ) High school degree

( ) GED

( ) College credits. If so, number of years attended _____

Degrees received:_____

( ) Currently in school. If so, where _____

OCCUPATION:

Currently working? _____ Employer and description of job, (include homemaking and parenting)_____

_____

_____

How long? _____

Please list important prior occupation(s):

Dates: Type of work:

_____ _____

_____

CURRENT CIRCUMSTANCES:

Married ?_____years current marriage____ number previous marriages____

Committed (not married) relationship? _____how long_____

Age of spouse or partner____ Occupation of spouse or partner_____

Divorced? ____ Number of divorces ____ when? _____

Separated? ____ when?____

Never married? ____ Widowed? ____ when? _____

Number of children____ Youngest age ____ Oldest age ____

Who is currently in your household? _____

_____

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Directions (general):
Fill in the following chart on a daily or weekly basis. Note the date that you start your ratings. Put a dot in the box that describes you mood for that day. Eventually connect the dots to make a graph. A scale appears beneath the chart to help evaluate your mood for the graph's scale.

Daily Charting for RAB:
- Best mood (high)
- Average (where mood most of the day)
- Worst mood (low)

	Date:							Date:							Date:							Date:							Date:						
	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F
90																																		
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Depression > > > > > > > > > > > > > > > > > "Normal" < < < < < < < < < < < < < < < < < Elation								
0 – 15 Extreme	16 – 25 Severe	26 - 35 Moderate	36 – 45 Mild	46 – 55 -----	56 – 65 Mild	66 – 75 Moderate	76 – 85 Severe	86 – 100 Extreme
Toally withdrawn, doesn't talk; unable to eat or responed; suicidal or too depressed to harm self hears voices of guilt, doom; hospitalization needed.	Needs prodding to function; serious sleep disorder; weight loss or gain; suicidal ideas very withdrawn; feels guild, self-hate, paranoia; may need hospitalization	Loss of energy interest, movement, desire to work; disturbed sleep, appetite, ability to function; withdrawn; desire to stay in bed; life not worthwhile	Feels unsuer, unfocussed, slowed down; lack of energy, optimism, pleasure, desire, sexual interest; crying spells	NORMAL	Feels wonderful, confident, perceptive, creative; Increased interest in travel, business, projects, sex, religion, spending money	Excessive confidence, activity, talking, thinking, travel, sex, irritability, controlling, spending money, decreased eating, caution, sleep (4-6 hours per night	Very repid talking, thinking; Very little eating sleeping, control; Unusual ideas, behavior, Religious fervor; Hostile; Many need to be hospitalized	Restless/ hyper; Hostile/Violent; Nonstop talking; Paranoid Hears voices Incoherent Can't function Elated or wild Little or no: eating sleeping control organization; Hospitalize