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New Patient Questionnaire

Patient Name: ____ Date: ________________

Demographic Information

1. Date of birth: ____________ Age: _____

2. Gender identity:
   ____ Male
   ____ Female
   ____ Transgender
   ____ Other

3. Ethnic identity:
   ____ African American
   ____ Asian
   ____ Hispanic/Latinx
   ____ Caucasian
   ____ Native American
   ____ Hawaiian/Pacific Islander
   ____ Biracial/Multiracial
   ____ Other: _____________

4. Relationship status:
   ____ Single
   ____ Married/Committed Relationship
   ____ Divorced
   ____ Widowed

5. Sexual orientation:
   ____ Heterosexual
   ____ Gay
   ____ Lesbian
   ____ Bisexual
   ____ Pansexual
   ____ Other/Unsure
   ____ Queer

6. Current employment status:
   ____ Employed – Job title:
   ____
   ____ Unemployed
   ____ Disability
   ____ Retired

7. Highest level of education:
   ____ Some high school
   ____ High school
   ____ Associate's degree
   ____ Bachelor's degree
   ____ Master's degree
   ____ Doctoral degree
   ____ Other

Physical Health

8. List any active health conditions (e.g., diabetes, cancer, heart disease, etc.):
____
____

9. Primary care provider name and contact information: ____

10. Do you experience physical pain on a regular basis? ____ No ____ Yes – How intense on scale from 0-10? __________

11. List prescription medications:
____
____

12. List non-prescription medications such as vitamins or supplements:
____
____

13. List any medication or food allergies:
____
____

Mental Health

14. List any mental health diagnoses previously received:
____
____

15. List any past mental health treatment (individual therapy, group therapy, or substance use treatment) and note anything that was helpful or unhelpful in those experiences:
____
____
____

16. List any prescription medications you have previously used for mental health symptoms (e.g., depression, anxiety, panic):
____
____

17. List any current prescription medications used to manage mental health symptoms:
____
____

18. Psychiatric provider and contact information: ____

19. List any hospitalizations for mental health symptoms – approximate date, reason, and length of stay:

____

____

____ Voluntary or ____ Involuntary?

20. List current mental health symptoms that cause concern:

____

____

21. What are your current therapy goals?

____

____

<u>Social Health</u>

22. Do you have any pending legal issues? ____ No ____ Yes

    If yes, please describe: ____

23. Do you prescribe to a particular religious belief system? ____ No ____ Yes

    If yes, which religion? ___________________________________

24. List family members who live with mental health issues or addiction:

____

____

____

25. List any supportive family members or friends in your life:

____

____

26. List any individuals you would like involved in your therapeutic process and how you would like them involved:

____

____

27. List any emotionally significant experiences in your childhood (e.g., parental divorce, traumatic experiences, abuse):

____

____

28. Describe your adult romantic relationship history (e.g., number and quality of relationships):

____

____

29. List any relationship challenges or concerns you may have:
____
____

30. Do you have a pet? ____ No ____ Yes

31. List hobbies, interests, or leisure activities:
____
____

Reproductive/Sexual Health

32. Are you currently sexual active? ____ No ____ Yes
    If yes, are you practicing safe sex (i.e., use of condoms, dental dams)? ____ No ____ Yes
    If yes, are you using birth control? ____ No ____ Yes – Type: _________________________
    Do you feel sexual satisfied in your life? ____ No ____ Yes
    Would you like to discuss sex related concerns in therapy? ____ No ____ Yes

33. How many child do you have? _____

34. List any fertility or sexual health concerns:
____
____

35. Are you currently pregnant? ____ No ____ Yes – Due Date: __________________

36. Have you struggled with pregnancy loss in the past? ____ No ____ Yes

37. Do you have a history of postpartum mental health issues such as depression or anxiety? ____ No ____ Yes

Behavioral Health

38. Do you use caffeine? ____ No ____ Yes – Amount per day: _______________________________________

39. Do you use tobacco products? ____ No ____ Yes – Amount per day: _________________________________

40. Do you use alcohol? ____ No ____ Yes – Amount per day: ____

41. Do you use marijuana? ____ No ____ Yes – Amount per day: ______________________________________

42. Do you use other illicit drugs? ____ No ____ Yes – Type and how often: ___________________________

43. Do you restrict food intake? ____ No ____ Yes

44. Do you engage in binge eating (i.e., eating large amounts of food and feeling like you cannot stop)? ____ No ____ Yes

45. Do you engage in purging behaviors (i.e., laxative use, excessive exercise, vomiting) after eating? ____ No ____ Yes

46. Do you need help with daily living activities such as bathing, dressing, or eating? ____ No ____ Yes

47. Do you engage in self harm behaviors such as cutting, burning, scratching, hitting, etc.? ____ No ____ Yes
    If yes, please describe type and frequency: ____

48. Do you have a history of suicidal actions such as attempts or planning behaviors/thoughts? ____ No ____ Yes
    If yes, please describe type and frequency: ____

49. Do you have any current thoughts of suicide? ____ No ____ Yes

50. Do you have a suicide plan? ____ No ____ Yes – Describe: ____

51. Do you have any intention of enacting suicide plan? ____ No ____ Yes – Describe: ___________________________________

52. Do you have any current thoughts of harming someone else or someone's property? ____ No ____ Yes

53. Do you have a plan to harm another or their property? ____ No ____ Yes – Describe: _________________________________

54. Do you have any intention to harm another or their property? ____ No ____ Yes – Describe: ___________________________

Patient Health Questionnaire-9 (PHQ-9)

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

Symptom	Please circle one response for each symptom			
	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing 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 overeating	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 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	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

Total score = ________

If you endorsed any symptoms above, 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?

____ Not difficult at all
____ Somewhat difficult
____ Very difficult
____ Extremely difficult

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Generalized Anxiety Disorder 7-Item Scale (GAD-7)

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

Symptom	Please circle one response for each symptom			
	Not at all	Several days	Over half the days	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's 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

Total score = ________

If you endorsed any symptoms above, 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?

____ Not difficult at all
____ Somewhat difficult
____ Very difficult
____ Extremely difficult

Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. Arch Intern Med. 2006;166:1092-1097.

PTSD Checklist-5 (PCL-5)

Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

In the past month, how much were you bothered by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stress experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience (e.g., heart pounding, trouble breathing, sweating)?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience (e.g., people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world (e.g., having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experience positive feelings (e.g., being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4

16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being “superalert” or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

Total score = ________