Lifeline 2 Wellness, A Nursing Corporation
901 Dove Street, Suite 299, Newport Beach, CA, 92660

New Patient Questionnaire

In an effort to utilize our time together more efficiently, please provide the information requested on the following pages and be as thorough as possible when answering the questions. Indeed this is an extensive set of questions, with some being of sensitive nature and difficult for you to disclose. Your most candid disclosure is essential as it assists in concise evaluation and accurate diagnosis and treatment plan. Feel free to use the back of the form as needed.

Thank You.
Jacqueline D. Bredehoft, PMHNP-BC
Email: Lifeline2wellness2013@gmail.com

Patient Information:

Patient's Name:	Social Security Number (SS#):	
Gender: Please Indicate: Female / Male		
Date of Birth:	Age:	
Marital Status: Single / Married / Separated / Divorced / Widowed		
Home Address:		
Home Phone:	Mobile:	
Email Address:		
Driver's License Number:	State:	
Occupation:		
Employer/School (if student):		
Responsible Party *(skip if Patient is also Responsible Party):*		
Responsible Party's Name:		
Relation to patient:		
Social Security number:	Date of Birth:	Age:
Home Address:		
Home Phone:	Mobile:	
Occupation: ____		
Employer addres/phone:		
E-mail Address:	Driver's License Number:	State: _______
Referral Source (who referred you to us):		
EMERGENCY CONTACT & CONFIDENTIALITY: Family member or next of kin we may contact in case of emergency:		
Phone number where you want to receive info about your appointments, lab results, etc:		
Can confidential messages be left on your telephone answering machine or voicemail? Yes ____No_____		

Questionnaire: To be answered by Individual seeking treatment.

What is the main purpose of your visit today? ____
____
What symptoms are you having? ____
____
How long have you had your concerns and symptoms? _____________________________________
____
Why seek treatment now? ____
____
Current life stressors: (include anything that is currently stressful for you, for example relationships, job school, finances, and children): ____
____

Are you wanting to hurt, harm, or kill yourself? Yes ____ No ____
Do you have a plan? Yes ____ No ____ Do you have the means available to you? Yes ____ No ____
Do you intend to carry out your plan? Yes ____ No ____
Do you have a history of cutting or burning yourself? Yes ____ No ____
Have you ever attempted suicide? Yes ____ No ____ If yes, how many attempts? ______
How old were you when you first tried? _______
How have you tried? ____
When did you last try? ____
Do you want to hurt or harm someone? Yes ____ No ____ Do you have a plan? Yes ____ No ____
Do you have a history of aggression towards others? Yes ____ No ____

__Past Psychiatric History__: **List all diagnosis' received, prescribers, therapists, medications, medical treatments, and hospitalizations that may or may not have helped.** (Please use back of form if needed) ____
____
____

Have you ever heard voices? Yes____ No____ Are you currently hearing voices? Yes ____ No ____
Have you ever seen things others would argue are not there? Yes ____ No ____
Are you currently seeing things? Yes ____ No ____
Have you ever believed people wanted to harm or hurt you? Yes ____ No ____
Do you currently believe people want to harm or hurt you? Yes ____ No ____
Do you have a history of mood swings affecting employment or relationships? Yes ____ No ____
Have you ever gone "for days" without sleeping because you did not feel the need to? Yes ____ No ____
How many nights? _______ How many times in your life? _______
How old were you the first time? _______ How old were you the last time? ________
Have you ever gotten into financial, legal, or occupational trouble for being extremely impulsive? Yes_____ No_____
Have you ever been hospitalized because someone felt you were acting bizarre, were out of control, were acting violently agitated? Yes ____ No ____ When? ______________________________________

__Medical History__: **(**Please use back of form if needed)
Primary Medical Doctor's name and contact information: _____________________________________
____
List any medical conditions you are currently being treated for: ________________________________
____
List any surgeries and corresponding dates: ____
____
Contact information of "other" doctor's or health care practitioners you regularly see: _______________
____
Medication Allergies: Yes____ No_____ Names of medications and type of reaction: _____________
____

Have you been diagnosed as having HIV, AIDS, Hepatitis C, Tuberculosis? Yes ____ No ____
If yes, please indicate: ____
Do you have history of **motor vehicle accident, head trauma, loss of consciousness, or concussion**? Yes _____ No _____ If yes, please describe age, frequency, treatment ____________________________
____
Have you ever had any **seizures or seizure like activity**? Yes ____ No _____
If yes, describe: ____
Current Height and Weight: ____

Family Medical and Psychiatric History: (Please use back of form as needed)
Does anyone in your immediate or extended family have a psychiatric diagnosis? Yes ____ No ____
Please explain: ____
Has anyone in your immediate or extended family attempted or committed suicide? Yes ___ No____
Please explain: ____
Does anyone in your immediate or extended family have or had alcohol or drug addiction?
Yes ____ No ____ Please explain: _____________ ____
Have any of your parents been physically or sexually abused? Yes _____ No _____

Social History:
Where were you born? ____
Where and whom did you grow up with? ____
Do you have any religious preference or spiritual practice? Yes ____ No ____ Please describe _________
____
Parent's academic and occupational history: ____
Do you have any siblings? Yes _____ No_____ How many? ________
Did you get along with members of your family then? Yes _____ No _____
Who did you get along with the most? ____
Do you still get along? Yes _____ No _____
Who did you **not** get along with? ____
Why? ____
Have you ever been married? Yes _____ No _____ How many times? ____________________________
Are you still married? Yes _____ No _____ For how long? _____________________________________
If not married, are you currently in a relationship? Yes _____ No _____ How long? _________________
How many other long-term relationships lasting more than 1 year have you had? ___________________
Why did they end? ____
Current Marital or Relationship Satisfaction: Satisfied ______ Unsatisfied ______
What is your current family structure? ____
Who do you currently live with? ____
Do you have children? Yes _____ No _____ How many? ____________
How old? ____
Do you get along with them? Yes _____ No ______
Describe your relationship with your friends: ____
How would you describe yourself: ____
Describe your strengths: ____
What is your Cultural/Ethnic Background: ____
Significant Developmental Events (Please use back of form if needed)
What significant losses in your life have impacted you the most and how have they impacted you: ______
____
____
Have you ever been physically, sexually, verbally, emotionally abused? Yes ____ No ____
Please explain: ____

Have you witnessed or experienced an event that left you traumatized, and now experience nightmares, hypervigilance, hyperstartle because of it? Yes ____ No ____Please explain: ________________________
____

School History:
Last grade completed: ______________________________
Last school attended: ____
Average grades received: ___________________________
Specific learning disabilities if any: ____
Learning strengths: ____
What would have your grade school teachers said about you: ______________________________
Did you have behavioral problems in school? Yes ___ No ___ Please describe if any _______________
____

Employment History: (summarize jobs you've had, list most favorite and least favorite):
Have you had any work related problems? Yes ____ No ____ Describe _________________________
____
What would your employers/supervisors say about you? ____________________________________

Military history: Yes ____ (Thank you) No _____
Have you been in active combat? Yes___ (Thank you) No ___ How many tours have you served and have they been concurrent (back to back): ______________________________________ Have you been injured? Yes ____ No ____ Please explain: __________________
Have you been diagnosed with PTSD? Yes____ No ____
If yes, are you currently experiencing nightmares, hyper-vigilance, and tendency to have outbursts? Yes____ No____. If yes, please describe: ____

Legal History:
Have you ever had any legal problems? Arrests, Incarcerations, Traffic Violations? Yes____ No ____
If yes, how many? ______ When was the last time? ____
Reasons why? ____

Alcohol and Drug History:
Have you ever used drugs for recreational purposes or because you felt you needed them?
Yes _____ No _____
Please **list/circle all that apply**: alcohol, prescription tranquilizers, pain medicines, sleeping pills, marijuana, hash; inhalants (glue, gasoline, cleaning fluids, etc.), cocaine, crack, amphetamines, crank, ice, steroids, opiates (heroin, codeine, morphine, or other pain killers); barbiturates, hallucinating drugs (LSD, mescaline, mushrooms), PCP, Ecstasy, Spice or 'bath salts', Roxies, etc. _________________________
*Any I. V. drug use? Yes ____ No ____ If yes, have you shared needles? Yes ____ No _____
*How old were you when you first used? __________ *How often? ______________________________
*What did you use first? ____
*Are you still using? Yes ____ No ____ *How often? ____
What? ____
*How have each of the substances made you feel while using them? ______________________________
____
*How have you felt when not using the substances? ____
*Have you experienced withdrawal symptoms, and if so, please describe? _______________________
____
*Have you ever felt you should cut down on alcohol or drug use? Yes ____ No ____
*Have loved ones been annoyed or criticized you for using alcohol or drugs? Yes _____ No _____
*Have you ever felt guilty about your alcohol or drug use? Yes ____ No _____
*Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?
Yes _____ No _____
*Have you ever used medication or other substances to come down from being high? Yes____ No ____
If yes, please explain: ____

*Have you ever gone to rehab? Yes ___ No ____ How many times?______ When was the last time? ____

*Have you ever had a seizure while using or coming off drugs or alcohol? Yes ____ No ____
Please explain: ____

*Have you ever blacked out while drinking? Yes ____ No ____
Please explain: ____

*Have you ever overdosed? Yes ____ No ____
Please explain: ____

Nicotine use (cigarettes, cigars, tobacco, chew): Yes _____ No_____
If yes, at what age did you start? ________ Are you still using nicotine? Yes____ No____
If yes, How much, and how often? ____
If you have stopped, when did you? ____

Diet/Exercise History:
Would you consider your diet mostly healthy or unhealthy?
Any food allergies/sensitivities you are aware of? Yes _____ No ______ Please explain ______________
____

Caffeine consumption per day (i.e. coffee, soda, tea, chocolate): ______________________________
How many servings of fruits and vegetables do you have per day? ________________________________
Do you eat breakfast? **Yes _____ No _____**
How many times a day do you eat? ____
How often do you have a bowel movement? ____

Describe your current exercise regimen: ____

Sleep Behavior:
Any problems falling asleep? Yes_____ No _____
Any problems staying asleep? Yes_____ No _____
Any problems waking up? Yes _____ No_____
On average, how many hours do you sleep per night? ___________
Any history of sleepwalking, sleep paralysis, recurrent dreams, sleep apnea, heavy snoring, or sleep bruxism (grinding your teeth)? If yes, please explain: ____

Sexual history:
(Answer only as much as you feel comfortable)
Age at the time of first sexual experience: _________________
Number of sexual partners you have had: __________________
Any history of sexually transmitted disease? Yes _____ No _____
If yes, with which have you been diagnosed? ____
*Have you ever been sexually abused, molested, or raped? Yes _____ No _____
If yes, how old were you? ______ Did you know the person? Yes _____ No _____
Have you ever received psychotherapy/counseling, EMDR because of it? Yes _____ No _____
Do you currently experience sexual problems related to the abuse? Yes _____ No ______
If yes, what type of problems? ____
*Have you ever been physically abused? Yes ____ No ____
If yes, how old were you? ______________Who abused you? ___________________________________
Are you currently in a physically, mentally, emotionally, verbally abusive relationship?
Yes _____ No _____ If yes, Do you fear for your safety and wellbeing? Yes _____ No _____
If yes, please describe: ____

Female patients only:
Date and length of your last menstrual period: ____
Do you suffer premenstrual moodiness, bloating, sugar, salt cravings and fatigue? If yes, How many days before and during your period____
How many pregnancies have you had? ______ Any complications? Premature births? Miscarriages?
Type of birth(s)? C-section, vaginal delivery, V-back

*Have you experienced Post-partum depression lasting more than three days? Yes ____ No ____
If yes, for how long were you depressed? _____ How many times? _____ Are you still depressed?
Yes ____ No ____
Selective termination of pregnancies? Yes _____ No _____ If yes, please describe___________________
What form of birth control are you currently using? ____
If not menstruating, are you in menopause? Yes ____ No ____
At what age did you begin menopause? ______ What are your symptoms? ________________________

Male patients only:
Do you experience fatigue, problems with memory and focus, loss of libido, loss of strength and muscle mass, crying easily, irritability?
Yes ____ No ____

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1. Describe your body type: ____ Slight ____ Medium ____ Overweight ____ Heavy ____ Obese
2. Do you appear to be your: ____ Stated age ____ Older ____ Younger ____ Other
3. Your hygiene and dress could be described as ____ Well dressed ____ Neatly groomed/casually dressed____ Sloppily dressed ____ Poor hygiene ____ Unusual appearance: ____
Please describe what you are wearing today: ____
4. How would you describe your attitude today? ___Cooperative ___ Uncooperative ___ Guarded ___ Suspicious ___ Angry ___ Hostile ___ Agitated ___Other: ___________________________________
5. Describe yourself: ___ Calm ___ Hyperactive ___ Tremors/tics ___ Retarded (Slow) ___ Restless ___ Lethargic____ Other: ____
6. Describe your speech: ____ Clear ____Pressured ____ Soft ____ Monotone ____ Not organized ____ Rapid ____ Slowed ____ Loud
7. Orientation: Please list the: Date: ___________ Day: _________ Year: ________ Month: _________
8. Memory: (check if intact)
   __ Recent, what did you have for breakfast? ____
   __ Remote, Where were you born? ____
   __ Immediate, what is my name? ____
   __ Is your memory decreased relative to normal: Is your memory less good than normal?

____

9. Concentration: Are you having problems with your concentration compared to normal for you? Your concentration is: ____ Normal ____ Mild Impairment ____ Moderate impairment (Somewhat decreased) ____ Marked impairment (Very decreased) Please explain: ____________________________

Thank you for your time.

FOR NURSE PRACTITIONER USE ONLY:

	Diagnostic description	Diagnostic Code	Notes [Indicate Primary DX with *]
Psychiatric			
Substance			
Medical			

BRIEF CASE FORMULATION:

____

____

____

TREATMENT PLAN:

____

____

____

____

____

Follow up appointment scheduled for:

____

____

Jacqueline D Bredehoft, PHMHNP-BC Date