PATIENT QUESTIONNAIRE

Emotional Wellness Center of Valdosta

The purpose of this questionnaire is to better understand the needs of the patient and to help guide treatment. Please answer the following questions honestly. All information shared will remain confidential in accordance with state and federal laws. If you are completing this form on behalf of the patient, note that the term "you" refers to the patient.

PATIENT INFORMATION

Your Name : _____ **Today's Date :** _____

Name of Patient (If not yourself) : _____

Date of Birth : _____ **Phone # :** _____

Address : _____

_____

Email : _____

Referral Source : _____

◯ **Primary Insurance** ◯ **EAP :** _____ ◯ **SELF PAY $125.00**

ID : _____ **# of Visits :** _____

Insurance Name : _____

Member ID : _____ **Group ID :** _____

Policy Holder Name: _____ **Date of Birth:** _____

Insurance Contact Number : _____

What do you hope to gain from your visit(s)? : _____

Have you benefitted from mental health treatment or an evaluation before? : _____

In your own words, describe your concerns/problems as you see them?:

_____

_____

_____

How long has this been going on?: _____

What have you done to cope? Has anything been helpful?:

_____

_____

_____

SYMPTOMS

*Please check any symptoms or experiences that you have had in the last **MONTH** :*

□ Depressed mood
□ Sadness
□ Rapid mood changes
□ Irritability
□ Hopelessness
□ Helplessness
□ Worthlessness
□ Decreased energy
□ Increased energy
□ Feeling numb
□ Racing thoughts
□ Withdrawing from others
□ Spending increased time alone
□ Difficulty leaving your home
□ Difficulty meeting role expectations (e.g., work, school, family)
□ Ineffective communication
□ Difficulty or inability to say "no" to others
□ Concerns about your sexuality
□ Dependency on others
□ Manipulating others to fulfill your own desires
□ Abusive relationship
□ Difficulty concentrating or thinking
□ Difficulty problem-solving
□ Racing thoughts
□ Large gaps in memory
□ Hearing voices when no one is present
□ Seeing unusual things (e.g., flashes of light, shadows)
□ Feeling your thoughts are being controlled or inserted into your mind
□ Belief that the TV or radio is communicating with you
□ Changes in eating/appetite
□ Eating more
□ Eating less
□ Binge eating
□ Self-induced vomiting (e.g., after eating)
□ Use of laxatives
□ Excessive exercise to avoid weight gain
□ Are you trying to lose weight?
□ Weight gain: _____ lbs.
□ Weight loss: _____ lbs.

□ Difficulty falling asleep
□ Difficulty staying asleep
Average hours of sleep per night: _____
□ Difficulty getting out of bed
□ Not feeling rested in the morning
□ Nightmares
□ Self-mutilation/cutting
□ Thoughts of harming or killing yourself
□ Thoughts of harming or killing someone else
□ Anxiety
□ Frequent worry
□ Panic attacks
□ Easily startled, feeling "jumpy"
□ Sense of lack of control
□ Increased muscle tension
□ Difficulty catching your breath
□ Unusual sweating
□ Tremor
□ Dizziness
□ Intrusive memories
□ Flashbacks
□ Feeling detached or outside yourself
□ Feeling puzzled as to what is real and unreal
□ Avoiding people, places, activities, or specific things
□ Nightmares
□ Feeling/acting like a different person
□ Easily startled
□ Thoughts about harming or killing yourself
□ Thoughts about harming or killing someone else
Obsessions, Compulsions & Fears
□ Repetitive behaviors or mental acts (e.g., counting, checking, hand washing)
□ Persistent, intrusive thoughts, impulses, or images
□ Fear of certain objects or situations (e.g., flying, heights, bugs)
Describe:
_____
□ Outbursts of anger
□ Inappropriate expressions of anger
□ Difficulty expressing emotions
□ Decreased ability to handle stress

Please describe any other symptoms or experiences you have had problems with:

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Are you currently taking any PSYCHIATRIC medication? __ YES __ NO If yes, please list.:

Medication	Dosage	How long have you taken it?

Are you currently taking any NON- PSYCHIATRIC medication? __ YES __ NO If yes, please list.:

Medication	Dosage	How long have you taken it?

Have you been hospitalized for PSYCHIATRIC reasons? __ YES __ NO If yes, please list.:

Hospital	Dates	Reason

Have you ever attempted suicide? __ YES __ NO
If yes, please describe.:

Are you CURRENTLY under any treatment for any medical condition? __ YES __ NO
If yes, please describe.:

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FAMILY HISTORY

PARENT 1: Age: _____ __ Living __ Deceased Cause of death : _____

PARENT 2: Age:_____ __ Living __ Deceased Cause of death : _____

Brothers and Sisters :

Name	Age	Are you Close? Y or N

During your childhood, did you live any significant period with anyone other than your natural parents?
__ YES __ NO

If yes, please give the person's name and relationship to you.:_____

Marital Status *(Circle One)*:

Single Divorced Remarried Engaged Widowed Separated Cohabitating Married

If applicable, Please tell us about your Partner:

Name : _____ Age: _____

If you have children, please tell us their names and ages:_____

_____

Who currently lives in your home?:_____

_____

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EDUCATION

Highest level of education completed:_____ Degree obtained, if applicable :_____

Did you have any disciplinary problems in school? __ YES __ NO If yes, please describe. :

_____

Were you considered hyperactive/ADHD in school? __ YES __ NO If yes, please describe. :

_____

If yes, were you on any medication? __ YES __ NO If yes, what medication? :

_____

What type of grades did you get in school?

_____

Have you ever served in the military __ YES __ NO If yes, please briefly describe. :

_____

EMPLOYMENT

Are you currently employed? __ YES __ NO

What type of work do you do?:

_____

Have you been arrested? __ YES __ NO If yes, please describe.:

_____

Do you have a religious affiliation? __ YES __ NO:

What kind of social activities do you participate in?

_____

Who do you turn to for help with your problems?:

_____

Have you ever been abused? (Circle what applies):

Verbally Emotionally Physically Sexually Neglected

Please describe :

_____

_____

_____

SUBSTANCE ABUSE

Do you drink alcohol? __ YES __ NO If yes, age of first use. :_____

How much do you drink? : _____

How often do you drink? : _____

Have you ever passed out from drinking? __ YES __ NO If yes, how often? :

_____

Have you ever blacked out from drinking? __ YES __ NO If yes, how often? :

_____

Have you ever had the "shakes"? __ YES __ NO If yes, how often? :

_____

If applicable: Have you ever felt you should cut down on your drinking/drug use? __ YES __ NO

If applicable: Have people annoyed you by criticizing your drinking / drug use? __ YES __ NO

If applicable: Have you ever felt bad or guilty about your drinking / drug use? __ YES __ NO

If applicable: Have you ever drank/used drugs in the morning to steady your nerves or relieve a hangover? __ YES __ NO

Do you use tobacco? __ YES __ NO

Please indicate any other drugs you have used, how long and the last time you used:

_____

_____

_____

Is there anything else you would like us to know about you?

_____

_____

_____