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New Patient Questionnaire Sheet

Today's Date: ________________

Name: ________________________________ **Date of Birth:** ______________ **Age:** _________ **Referred by:** ____________________

Major Complaint/Problem: (Reason You are seeing the Psychologist/Doctor): ____

____

____

____

Date of your complaint/impairment/injury onset? (Estimated Date) ________________________________

Developmental History (Specify on line provided):

Birth Place: ________________________________ **Place Raised:** ________________________________

Number of Siblings: __________________ Your Order (First, Middle, etc.): ________________________________

Mother's Age at Birth: __________ Mother's Occupation During your Childhood: ______________________

Relationship with Mother through Childhood: ____

Father's Age at Birth: __________ Father's Occupation During your Childhood: ______________________

Relationship with Father through Childhood: ____

List if Other Raised you: (Stepfather, Grandma, etc.) ____

From what age did they raise you? ____________________ To what age did they raise you if not 18? ______

Their Occupation During your Childhood: ____

Relationship them through Childhood: ____

Developmental History Continued (Check all that apply, specify on line provided):

Birth Complications

- ☐ Low Birth Weight
- ☐ Oxygen Deprivation
- ☐ Premature
- ☐ Deformity (specify) _____________
- ☐ Illness (specify) _____________
- ☐ Birth Trauma

Developmental Milestones (Check, if any, event(s) were delayed/impaired during infancy/toddler stages):

- ☐ Standing
- ☐ Bedwetting
- ☐ Potty Training
- ☐ Talking
- ☐ Walking

Childhood Diseases/Surgeries:

- ☐ Loss of Consciousness
- ☐ Accidental Poisoning
- ☐ Multiple Sclerosis
- ☐ Seizure
- ☐ Encephalitis
- ☐ Allergies _______________
- ☐ Concussion
- ☐ Meningitis
- ☐ Cut Requiring Stitches
- ☐ Oxygen Deprivation
- ☐ Appendectomy
- ☐ Asthma/Bronchitis
- ☐ Tonsillectomy
- ☐ High Fever (over 104F)
- ☐ Broken Bones _______________
- ☐ Near Drowning
- ☐ Cerebral Palsy
- ☐ Cancer
- ☐ Convulsions
- ☐ Pneumonia
- ☐ Other ____________________

Educational History

Special Education Classes/Learning Disabilities

- ☐ Yes, List ________________________________
- ☐ No

Schools Attended (List Schools Attended from High School through College/Professional School by Age):

Name of School	Located in City, State	Attended From what Age to What Age? (ex. 14-18)	Dates Attended	Degree/Special Awards Earned	GPA
1.					
2.					
3.					
4.					

Occupational History (List Summary of Job/Career History from past to present):

Company	Job Title	Approximate Dates From Date to End Date	Tasks of Job	Problems with Job? If Yes, list specific problems.
1.				
2.				
3.				
4.				

Disability Status (Have you been determined Disabled?)

☐ Yes, Specify:___________________________ ☐ No

Military Service

Branch	When ?	Length of Service	Where?	Rank	Service related injuries, disorders, limitations, exposures, etc.

Legal History

(Check the box(s) of all legal matters you have been involved in from school age to present, then explain checked items in the table that follows)

☐ Truancy
☐ School Suspension
☐ Court matters
☐ Misdemeanor Charges
☐ Felony Charges
☐ Jail/Prison Time
☐ Probation/Parole
☐ Victim of a Crime
☐ Victim of Violence
☐ Lawsuit
☐ DUI
☐ Assaults
☐ Drug Possession Charges
☐ Public Intox
☐ Other Legal Charges
☐ Accused of Abuse
☐ Victim of Abuse
☐ Parental Rights Taken by DHS/other legal entity
☐ Other:________________

Legal History Detail

What:	Explanation/Further Details:	When (Estimated Date):	Where (What State/Specific Legal Entity):	Result/Consequences:

Substance Use

What Substance? Tobacco? Alcohol? Marijuana? Prescription Pills? Cocaine? Meth? Etc. List All.	Used From What Age to What Age?	How often and How much each time?	Any Legal or other Consequences from using?

Current History

Place an (X) in front of items you have or have had problems with:

____ Acid reflux (heartburn)
____ Alcoholism / other addiction
____ Allergies (environmental)
____ Anxiety
____ Asthma
____ Arthritis
____ Cancer (specify type ___________________)
____ Coagulation (bleeding or clotting) problem
____ Cholesterol problem
____ Chronic low back pain
____ Dementia
____ Depression
____ Diabetes mellitus
____ Erectile dysfunction
____ Gastric (GI) Issues
____ Head Injury
____ Heart disease (specify type______________)
____ Hypertension (high blood pressure)
____ Irritable bowel syndrome
____ Irregular Heart beat/rhythm
____ Migraines
____ Musculoskeletal Problems
____ Osteopenia or Osteoporosis
____ Prostate problem
____ Pulmonary Issues (Lung/Breathing)
____ Stroke
____ Thyroid problem
____ Urinary Issues
____ Brain Injury
____ Other Problems/Disorders/Diseases (list below):

____

____

____

Review of Symptoms

Place an (X) in front of items you have:

Vision:

_____________ Glasses/Contacts
_____________ Blurred or Double Vision
_____________ Loss of Vision/Blind Spots

Hearing:

_____________ Hearing Aid (left, right, or both ears)
_____________ Loss of Hearing
_____________ Ringing
_____________ Tone Deafness
_____________ Ear infections (tubes placed)

Motor: (specify where on line)

_____________ Decreased Coordination
_____________ Weakness
_____________ Paralysis
_____________ Spasms/Tremors
_____________ Chewing/Swallowing
_____________ Range of Movement/Flexibility

Pain: (specify where on line)

_____________ Chronic Pain (Long term)
_____________ Acute Pain (Short term, due to injury, sprain, etc)

Tactile: (specify where on line)

_____________Numbness/Loss of Sensation
_____________Tingling/Burning
_____________Pain/Temperature Sensitivity

Taste & Smell:

_____________Change in Taste
_____________Bad Tastes
_____________Change in Smell
_____________Bad Smells

Consciousness:

_____________Seizures or Fits
_____________Fainting or Blackout Spells
_____________Lapses of Time
_____________Dizziness While Sitting
_____________Dizziness Upon Standing
_____________Staring Episodes

Review of Cognitive Symptoms

Place an (X) in front of items you have:

Attention:

_____________ Distractibility
_____________ Confusion/Orientation Deficits (forgetting day, date, or whereabouts)
_____________ Concentration Deficits (Must repeatedly read a book or newspaper before it makes sense. Cannot follow television show from start to finish)
_____________ Path Finding Problems (Patient gets lost going to familiar places and/or has problems taking a bus)

Memory:

_____________ Immediate Memory (names, faces, telephone numbers)
_____________ Visual Memory Problems
_____________ Verbal Memory Problems
_____________ Memory Change (example) ______________________________________
_____________ Short-term Recall - Difficulty remembering newly learned experience.
_____________ Long-term or Remote Recall - Difficulty remembering past experiences/events
_____________ Absent-Mindedness
_____________ Memory for Names/Faces
_____________ Memory for Numbers
_____________ Old Learning (e.g., taking a bus, cooking a meal/dish, simple math/spelling)
_____________ New Learning (able to learn something new involving 3 or 4 steps)

Speech:

_____________ Difficulty Expressing Thoughts
_____________ Difficulty Understanding Others
_____________ Change in Articulation/Slurred or Mumbled Speech
_____________ Trouble Finding Correct Word or Desired Word
_____________ Saying Wrong or Inappropriate Word
_____________ Word-naming Problems
_____________ Hesitations
_____________ Substitutions
_____________ Speech Impediments
_____________ Difficulty Constructing Sentences

Thought Processes:

_____________ Trouble Organizing Thoughts
_____________ Trouble Organizing Actions
_____________ Slowed Thinking
_____________ Decreased Problem Solving Ability
_____________ Changes in Ability to Read
_____________ Changes in Ability to Write
_____________ Changes in Ability to Spell
_____________ Changes in Ability to do Math

Other Symptoms:

_____________ Unexplained or Increased Crying Capacity
_____________ Sadness
_____________ Hyperactivity
_____________ Temper Outbursts
_____________ Irritability/Argumentativeness
_____________ Impulsiveness
_____________ Change in Motivation
_____________ Loss of Pleasure
_____________ Anxiety/Tension/Nervousness
_____________ Fears
_____________ Social Withdrawal/Isolation
_____________ Change in Alcohol or Tobacco Use
_____________ Racing Thoughts
_____________ Worry
_____________ Sleep Change (specify) _______________
_____________ Number of Hours per Night____________
_____________ Stress-related Sleep Difficulties
_____________ Weight Loss/Gain
_____________ Appetite Change
_____________ Intentional Weight Loss
_____________ Libido Changes
_____________ Mood Swings
_____________ Agitation/Panic Attacks
_____________ Hallucinations
_____________ Delusions
_____________ Suicide Attempts/Gestures/Ideation
_____________ Suicidal Thoughts/Ideation

Activities of Daily Living

Describe your current functioning level in each area by placing a number(0-3) on the first line labeled *Number*. Then list any problems, difficulties, or factors that may cause difficulties in this area on the line beside it.

Number:	***Examples of* Problems/Factors Affecting Functioning*:***		
0= I can't do or participate in this task at all.	Stamina	Strength	Self Discipline
1= I can marginally do or participate in this task.	Memory	Mental	Commitment
2= I can reasonably do or participate in this task.	Anxiety	Depression	Concentration
3= I do or participate in this task very well.	Stress	Physical Limitations	Other-Please specify

	Number	**Problems/Factors Affecting Functioning**
Cooking & Meal Preparation:	_________	____
Laundry and clothing care:	_________	____
Grocery Shopping:	_________	____
Organization, Tidiness and Routine Cleaning:	_________	____
Ability to Manage, Budget and Save Money:	_________	____
Compliance to Healthy Diet Everyday:	_________	____
Daily Exercise of at least 30 minutes:	_________	____
Bathing, Coordinating Outfits, Grooming:	_________	____
Social Activities and Functions Involvement:	_________	____
Recreational Hobbies & Activities:	_________	____

Current History

Handedness(circle one): Right Left Ambidextrous. **Highest Education Level Completed**____________

Current Occupation:__________________________________**Current work hours per week**:________________

Ethnicity:___________________ **Religious or Other Group Affiliation**:__________________________________

Marital Status (Circle one): Single Married Divorced Remarried Separated Widowed

Number of Children:_________**List Children's ages**:____

Current Living Arrangements (Circle one): Live Alone Live w/ Roomate Live w/ Spouse Live w/ Parents Nursing Home

Other:____

List Recreational Activities:____

List Group(s) or Organization(s) involved in:____

ADDITIONAL INFORMATION YOU WOULD LIKE TO COMMUNICATE TO DOCTOR:

____

____

____

____

____

____

Current Medication List:

Medication Name	Dose (mg)	How Often (Once Daily, 2x day, PRN, etc.)	For what? (Pain, HTN, DM, etc.)

Health Care Providers:

Primary

Name:____Type:_____________

Ph#:______________________________Fax#__________________________

Address: ____

City___________________State_______________Zip______________

Mental Health

Name:____Type:_____________

Ph#:______________________________Fax#__________________________

Address: ____

City___________________State_______________Zip______________

Other

Name:____Type:_____________

Ph#:______________________________Fax#__________________________

Address: ____

City___________________State_______________Zip______________