Alabama Psychiatric Services, P.C.

Adult Patient Questionnaire

Patient Name: _____Date: _____

Please read the following questions and answer to the best of your ability by placing a checkmark in the appropriate boxes or fill in the blank as directed. Your cooperation is appreciated.

Referred by: _____

Please state in your own words why you have come to Alabama Psychiatric Services today:

_____

_____

_____

_____

_____

_____

_____

Please check ALL of the following symptoms or thoughts that apply to you <u>AT THIS TIME or during the past six months:</u>

- ❑ Depressed mood
- ❑ Diminished interests or pleasure
- ❑ Sleep disturbance
- ❑ Fatigue
- ❑ Change in appetite
- ❑ Hopelessness
- ❑ Pleasure in few activities
- ❑ Weight change
- ❑ Agitation
- ❑ Excessive worry
- ❑ I feel like I am losing control
- ❑ Irritability
- ❑ Poor Concentration
- ❑ Tension
- ❑ Feelings of panic
- ❑ Socially withdrawn
- ❑ Use of alcohol
- ❑ Use of other drugs
- ❑ Use of tobacco
- ❑ Anxiety in social settings
- ❑ Makes careless mistakes
- ❑ Does not complete tasks
- ❑ Difficulty organizing
- ❑ Forgetful
- ❑ Confusion
- ❑ Disorientation
- ❑ Compulsive checking / counting
- ❑ Indecisiveness
- ❑ People talk about me
- ❑ Some people want to hurt me
- ❑ I feel emotionally distant from others
- ❑ I hear voices or sounds others do not hear
- ❑ I see things others do not see
- ❑ I smell things others do not smell
- ❑ Racing thoughts
- ❑ I do risky or dangerous things
- ❑ Little interest in sexual activity
- ❑ Sexual problems
- ❑ Gender concerns
- ❑ I don't like my body
- ❑ Binge eating
- ❑ Self induced vomiting
- ❑ Laxative abuse
- ❑ Excessive fasting
- ❑ Intense fear of weight gain
- ❑ Impulsive
- ❑ I think about hurting myself
- ❑ I have tried to hurt myself
- ❑ Sometimes I wish I were dead
- ❑ I think about hurting someone else
- ❑ Exposed to a significant traumatic event
- ❑ Recurrent distressing dreams

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Psychiatric History (Please check all that apply)

I have received treatment for:	**The treatment occurred at:**	**Are you presently being treated?**
❑ Substance abuse	❑ Alabama Psychiatric Services Office	❑ Yes
❑ Mental health	❑ Other private psychiatrist	❑ No
❑ Both	❑ Other counseling service	If yes, by whom?_____
	❑ Mental Health Center	
	❑ Hospital	_____
	❑ Other facility	

Medical History

Your current weight_____ Height in inches_____

Name of your primary care doctor:_____ Phone:_____

Date last seen: _____

Do you have a history of any medical problem?	❑ Yes	❑ No
Are you presently being treated for any medical problem?	❑ Yes	❑ No

Past surgeries: _____

_____

Date of last Menses:_____ What form of birth control do you use? _____

Have you ever been treated for a nutritional problem?	❑ Yes	❑ No
Do you make yourself sick because you feel uncomfortably full?	❑ Yes	❑ No
Do you worry you have lost control over how much you eat?	❑ Yes	❑ No
Have you recently lost more than 14 pounds in a 3 month period?	❑ Yes	❑ No
Do you believe yourself to be fat when others say you are too thin?	❑ Yes	❑ No
Would you say that food dominates your life?	❑ Yes	❑ No
Are you experiencing any physical pain?	❑ Yes	❑ No

Have you ever received treatment for any of the following medical conditions?

❑ Neurological impairment	❑ Cirrhosis	❑ Cancer
❑ Seizure disorder	❑ Hepatitis	❑ Thyroid disease
❑ Visual loss / impairment	❑ Heart condition	❑ Diabetes
❑ Hearing loss / impairment	❑ Hypertension	❑ Pregnancy
❑ Dementia	❑ Asthma	❑ Irregular menstrual periods
❑ GI disorder	❑ Emphysema	❑ Musculoskeletal condition
❑ Obesity	❑ Chronic bronchitis	❑ HIV / AIDS / Related condition
❑ Significantly underweight	❑ Tuberculosis / +PPD	❑ Other

Please list any medications you are presently prescribed. _____

_____

_____

Thank you for your cooperation and patience. Your therapist/physician will see you shortly and discuss these and other issues in greater detail and help you develop a treatment plan to effectively deal with these issues.