Patient Name _____ Todays Date _____

1. Describe the reason (s) for seeking help _____

_____

_____

2. Please list medications you are currently taking, including both psychiatric and those for other medical conditions

Name of Medication	Strength	Dosage/Directions

3. Do you have other medical conditions/surgeries? Ex high blood pressure, heart disease, thyroid, etc.

_____

_____

4. Please list allergies to any medications, if any _____

_____

5. Past psychiatric medications and side effects _____

_____

_____

GAD-7 (Modified Anxiety Rating Scale)

Over the last **TWO WEEKS**, how often have you been bothered by any of the following	Not at All	Several Days	More than 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 is 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
ADD EACH CIRCLED COLUMN				
OVERALL TOTAL				
10. If you circledd ANY problem(s) above, how difficult has it been to do your work, take care of things at home, or get along with other people	Not Difficult	Somewhat Difficult	Very Difficult	Extremely Difficult

Name: _____ Date: _____

Review of Systems/Symptoms (circle any current symptoms within the past TWO WEEKS otherwise check None

1. General/Constitutional	☐	None	Fevers	Weight Loss	Weight Gain	Other
2. Eyes	☐	None	New Blurred Vision			Other
3. Ears/Nose/Mouth/Throat	☐	None	Dry Mouth	Ears Ringing		Other
4. Cardiovascular	☐	None	Fast Heart Rate	Chest Pain	Chest Tightness	Other
5. Respiratory	☐	None	Shortness of Breath			Other
6. Gastrointestinal	☐	None	Constipation	Diarrhea	Nausea/Vomiting	Other
7. Genitourinary	☐	None	Urinary Problems		Low Libido	Other
8. Muscular/Skeletal	☐	None	Muscle/Joint Pain	Weakness	Falls	Other
9. Integumentary/Skin	☐	None	Increased Sweating			Other
10. Neurological	☐	None	Memory Problems	Headache	Dizziness	Other
11. Endocrine	☐	None	Heat/Cold Intolerance			Other
12. Hematologic/Lymphatic	☐	None	Easy Bruising/Bleeding		Blood Clots	Other
13. Allergies/Immune	☐	None	Anaphylactic Shock		Hives	Other
14. Psychiatric	☐	None	See Below			

PHQ-9 (Modified Mood/Depression Rating Scale

Over the last **TWO WEEKS**, how often have you been bothered by any of the following problems? (Circle the Number 0, 1, 2, or 3 for each row/question)	Not at All	Several Days	More than half the days	Nearly every day
1. Felt down, depressed, sad, tearful and/or hopeless	0	1	2	3
2. Trouble falling asleep, staying asleep, waking too early, OR sleeping too much	0	1	2	3
3. Little interest or pleasure in doing things	0	1	2	3
4. Felt worthless, hopeless, helpless, guilt, and/or failure	0	1	2	3
5. Low energy, feeling tired, or fatigues	0	1	2	3
6. Trouble with concentration (watching TV, reading, work, etc.), indecisiveness, and/or maintaining focus	0	1	2	3
7. Poor appetite or overeating	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed; OR, the opposite, feeling so fidgety or restless that you've been moving around a lot more than usual	0	1	2	3
9. Thoughts of not wanting to be alive, wishing to be dead, or considering harming yourself	0	1	2	3
ADD EACH CIRCLED COLUMN				
OVERALL TOTAL				

10. If you circled ANY problem(s) above, how difficult has it been to do your work, take care of things at home, or get along with other people	Not Difficult	Somewhat Difficult	Very Difficult	Extremely Difficult

Name: _____ Date: _____

Mood Disorder Questionnaire (MDQ) – Modified Please **Circle** the answer to each question to the best of your ability. **Has there ever been a period of time when you were NOT your usual self and ...**		
... you got much LESS sleep than usual and found you didn't really miss it?	YES	NO
... you had much MORE energy than usual?	YES	NO
... you were much MORE active or did many more things than usual?	YES	NO
... you were so EASILY distracted by things around you that you had trouble concentrating or staying on track?	YES	NO
... your thoughts RACED through your head, or you couldn't slow down your mind?	YES	NO
... you did things that were IRRITABLE that you shouted at people or started fights/arguments?	YES	NO
... you did things that were UNUSUAL for you or that other people might have thought were excessive, foolish, risky, or impulsive?	YES	NO
... you were MUCH more interested in sex than usual?	YES	NO
... SPENDING money got you or your family in trouble?	YES	NO
... you FELT SO GOOD or so HYPER that other people thought you were NOT your normal self or you were so hyper that you got in trouble?	YES	NO
... you felt much MORE self-confident than usual?	YES	NO
... you were much MORE social or outgoing than usual, for example, you telephone friends in the middle of the night, etc.?	YES	NO
... you were much MORE talkative or spoke much FASTER than usual?	YES	NO
Total CIRCLED YES'S from above = _____ out of 13		
If you checked YES to more than one of the above, have several of these ever happened during the same time period?	YES	NO
How much of a problem did any of this cause you, like being able to work; having family, money or legal troubles; getting into fights/arguments? **Please circle ONE response** No Problem Minor Problem Moderate Problem Serious Problem		
Have any of your blood relatives (children, siblings, parents, grandparents, aunts/uncles) had manic-depressive illness or bipolar disorder?	YES	NO
Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	YES	NO

Alcohol Screening Questionnaire (AUDIT) Name: _____ Date: _____

Answer the following questions and add up final score.

	0 Pts p/?	1 pt p/?	2 pts p/?	3 pts p/?	4 pts p/?
How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times p/month	2-3 times p/week	4+ times p/week
How many drinks containing alcohol do you have on a typical day when you are drinking?	1 - 2	3 - 4	5 - 6	7 - 9	10+
How often do you have more than 5 drinks in one sitting?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often during the last year have you found that you could not stop drinking once you started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often during the last year have you failed to do something that was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often during the last year have you needed a drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often during the last year have you had a feeling of guilt or remorse about your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
Have you or someone else been injured because of your drinking?	No		Yes, but in the last year		Yes, during the last year
Has a relative, friend, doctor or other health worker been concerned about your drinking and suggested you cut down?	No		Yes, but in the last year		Yes, during the last year
			Total Pts		

Do you smoke cigarettes? Yes No/Never No/ I used to

If yes how much do you smoke? _____

If No/I used to, when did you quit? _____

Do you use marijuana? Yes No

If yes, how often / how much? _____

Adult ADHD Self-Report Scale (ASRS-v.1) Symptom Checklist

Please answer the questions below, rating yourself on each of the criteria shown using the scale below. As you answer each question, place an X in the box that best describes how you felt and conducted yourself over the past 6 months.

Name: _____ Date: _____

Part A

	Never	Rarely	Sometimes	Often	Very Often
How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
How often do you have difficulty getting things in order when you have to do a task that requires organization?					
How often do you have problems remembering appointments or obligations?					
When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
How often do you feel overly active and compelled to do things, like you were driven by a motor?					

Part B

How often do you make careless mistakes when you must work on a boring or difficult project?					
How often do you have a difficulty keeping your attention when you are doing boring or repetitive work?					
How often do you have difficulty concentrating on what people say to you even when they are speaking to you directly?					
How often do you misplace or have difficulty finding things at home or at work?					
How often are you distracted by activity or noise around you?					
How often do you leave your seat in meetings or other situations in which you are expected to remain seated?					
How often do you feel restless or fidgety?					
How do you have difficulty unwinding and relaxing when you have time to yourself?					
How often do you find yourself talking too much when you are in social situations?					
When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to before they can finish them themselves?					
How often do you have difficulty waiting your turn in situations when turn taking is required?					
How often do you interrupt others when they are busy?					