Lakeland Regional Health®

NEW PATIENT QUESTIONNAIRE
ADULT

Welcome to Lakeland Regional Health!

At Lakeland Regional Health, our comprehensive behavioral health care for adults, children and adolescents provides collaborative and compassionate care for those who come to us for help. Our experienced mental health professionals look forward to working with you to help you achieve your goals.

The series of questions on the following pages helps us get to know you and understand what you are experiencing. If you have any questions about these questions or need any other assistance, please let a member of our team know.

Thank you,

Your Lakeland Regional Health Behavioral Health Sciences Team

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Today's date:	
Patient name (first, middle, last)	
Preferred Name	Birth date (mm/dd/yyyy)

REFERRAL AND GENERAL INFORMATION

Who referred you to our clinic/to this provider? _____

What are your main concerns, or how can we help? _____

_____

_____

How long have you felt this way? _____

DEVELOPMENTAL AND SOCIAL HISTORY

Where were you born and raised? _____

Were there any complications with your birth or any known developmental delays? ☐ Yes ☐ No

If Yes, explain: _____

Did your parents' divorce? ☐ Yes ☐ No

If so, what was your age when they divorced? _____

If your parents divorced, who raised you? _____

Describe your childhood? _____

_____

Describe your mother and your relationship with her:

As a child: _____

As an adult/now: _____

Age of Mother: _____ Living: ☐Yes ☐ No Cause of death, if deceased: _____

Describe your father and your relationship with him:

As a child: _____

As an adult/now: _____

Age of father: _____ Living: ☐Yes ☐ No Cause of death, if deceased: _____

Relationship status: ☐ Single ☐ Married ☐ Engaged ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

How long have you been in this relationship status? _____

If in a relationship, please describe your current relationship: _____

_____

Describe your past relationships? _____

_____

Have you had any prior marriages? ☐ Yes ☐ No If yes, explain (number and length of time): _____

_____

Do you have children? ☐ Yes ☐ No If yes, list ages and gender: _____

Describe your relationship with your children: _____

_____

Do you have any concerns about your children? ☐ Yes ☐ No

If Yes, please explain: _____

List everyone who lives with you: _____

Describe your social support system (ex. good, poor, fair, want more, none) and to whom you are closest?

_____

_____

Identified Gender: ☐ Female ☐ Male ☐ Trans female ☐ Trans male ☐ Nonbinary ☐ Other: _____

Identified Sexuality: ☐ Straight ☐ Bisexual ☐ Gay/Lesbian ☐ Questioning ☐ Other: _____

EDUCATION HISTORY

Highest grade completed? _____ College degree and area of study? _____

Describe your school experience (ex. GPA, received special services, bullied, activities) _____

_____

OCCUPATIONAL HISTORY

Employment status (check all that apply): ☐ Full-Time ☐ Part-Time ☐ Contract ☐ Student
☐ Disabled ☐ Retired ☐ Not formally employed ☐ Other: _____

What is your profession? _____

Are you happy with your place of work / employment status / profession / school? ☐ Yes ☐ No

Do you have military service experience? ☐ Yes ☐ No If yes, describe: _____

LEGAL HISTORY

Have you ever been arrested? ☐ Yes ☐ No What were the charges? _____

Do you have any pending legal or child custody concerns? ☐ Yes ☐ No

If yes please describe? _____

RELIGION/SPIRITUALITY

Do you believe in or belong to a particular religious or spiritual practice? ☐Yes ☐No

If yes, please describe?_____

What is the level of your involvement (e.g., attend services, pray, go to studies)? _____

FAMILY BEHAVIORAL HEALTH HISTORY

Has anyone in your family been diagnosed with or treated for any mental health or substance use concerns (or committed suicide): ☐Yes ☐No If Yes, please describe: _____

_____

PERSONAL BEHAVIORAL HEALTH HISTORY

Have you ever been hospitalized for psychiatric care? ☐Yes ☐No

If Yes, please describe the reason, when, where, and nature of treatment. _____

_____

Have you ever attempted suicide? ☐ Yes ☐No If Yes, when: _____

Have you participated in any self-help activities or groups (ex. AA/NA, books, NAMI)? ☐Yes ☐No

If Yes, please describe: _____

_____

Please share any preferences or barriers to treatment (ex. time, money, childcare, motivation, uncertainty/fears):

_____

Are you CURRENTLY under psychiatric care or attending therapy? ☐ Yes ☐No

If Yes, with whom? _____ Date of last visit: _____

Please list all of your **current** psychiatric medications:

Name of Medication	Dose and Frequency	Prescribed by	Is it working well for you?

Please list all of your **previous** psychiatric medications:

Name of Medication	Dose and Frequency	Prescribed by	Did it work for you?

Please list any past or present outpatient therapy/counseling that you have attended:

Type of Therapy (ex. couples, individual, group)	Dates you were in treatment	Provider

MEDICAL HISTORY - Please check any of the following you have been diagnosed with in the past.

☐ Anaphylaxis	☐ Easily bruised	☐ Hemophilia	☐ Parathyroid disease
☐ Anemia	☐ Emphysema	☐ High blood pressure	☐ Recent change in weight
☐ Arthritis	☐ Epilepsy or seizures	☐ High cholesterol	☐ Renal dialysis
☐ Artificial heart valve	☐ Excessive thirst	☐ Irregular heartbeat	☐ Sickle cell disease
☐ Asthma	☐ Fainting spells/dizziness	☐ Kidney problems	☐ Stroke
☐ Blood disease	☐ Frequent cough	☐ Leukemia	☐ Thyroid disease
☐ Breathing problem	☐ Frequent diarrhea	☐ Liver disease	☐ Traumatic brain injury
☐ Cancer	☐ Frequent headaches	☐ Low blood pressure	☐ Tuberculosis
☐ Chest pain	☐ Glaucoma	☐ Lung disease	☐ Other: _____
☐ Congenital heart disorder	☐ Heart attack/failure	☐ Multiple sclerosis	☐ Other: _____
☐ Dementia	☐ Heart murmur	☐ Night sweats	☐ Other: _____
☐ Diabetes	☐ Heart pacemaker	☐ Osteoporosis	

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Additional Screening Questions

Please answer the following questions:		YES	NO
1.	In the past four weeks, have you had an anxiety attack-suddenly feeling fear or panic?		
2.	How often has this happened in the past four weeks? _____		
3.	Do some of these attacks come suddenly out of the blue (in situations that you don't expect to be nervous or uncomfortable)?		
4.	Do these attacks bother you a lot or are you worried about having another attack?		
5.	During your last anxiety attack did you have symptoms like shortness of breath, sweating, shaky, or your heart racing, pounding, or skipping?		
6.	Do you have any specific fears that you feel afraid on a regular basis? If you checked yes, what is it? _____		
7.	In your life have you ever had any experience that was so frightening, horrible, or upsetting that in the past month you have: (Please check) ☐ had nightmares about it or thought about it when you did not want to? ☐ tried hard not to think about it or went out of your way to avoid situations that reminded you of it? ☐ been constantly on guard, watchful, or easily startled? ☐ felt numb or detached from others, activities, or your surroundings		
8.	Do you make yourself sick because you feel uncomfortably full?		
9.	Do you worry you have lost control over how much you eat?		
10.	Have you recently lost more than 14 lbs in a 3-month period?		
11.	Do you believe yourself to be fat when others say you are too thin?		
12.	Would you say food dominates your life?		
13.	Have you started to wonder if your mind was not working right?		
14.	Have you felt confused whether an experience was real or imaginary?		
15.	Have you seen objects, people, or animals that no one else could see?		

		YES	NO
16.	Have you heard voices or sounds that no one else could hear?		
17.	Have you thought that people were hearing your thoughts, following or spying on you?		
18.	Are you bothered by unpleasant thoughts, urges, or images that repeatedly enter your mind?		
19.	Are you feeling driven to perform certain behaviors or mental acts over and over again?		
20.	Do you feel detached or distant from yourself, your body, your physical surroundings, or your memories?		
21.	Do you drink alcohol or use drugs or other substances?		
22.	Have you spent more time drinking or using drugs than you intended to?		
23.	Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?		
24.	Has anyone objected to your drinking or drug use?		
25.	Have you found yourself thinking a lot about drinking or using drugs?		
26.	Have you ever used alcohol or drugs to relieve emotional discomfort, such as sadness, anger, or boredom?		
27.	Have you ever neglected some of your usual responsibilities because of drinking or using drugs?		
28.	If you drink, how many alcoholic drinks do you have on a typical day? _____		
29.	How often do you have five or more drinks on one occasion? _____		
30.	How often do you use marijuana, any other drug, or prescription medication to get high? _____ _____		

31.	Has there ever been a period of time when you were not your usual self and ... (Please check all that apply):
	☐ 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 into trouble?
	☐ you were so irritable that you shouted at people or started fights or arguments?
	☐ you felt much more self-confident than usual?
	☐ you got much less sleep than usual and found you didn't really miss it?
	☐ you were much more talkative or spoke much faster than usual?
	☐ thoughts raced through your head or you couldn't slow your mind down?
	☐ you were so easily distracted by things around you that you had trouble concentrating or staying on track?
	☐ you had much more energy than usual?
	☐ you were much more active or did many more things than usual?
	☐ you were much more social or outgoing than usual, for example, you called friends in the middle of the night?
	☐ you were much more interested in sex than usual?
	☐ you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?
	☐ spending money got you or your family into trouble?
32.	If you checked more than one above, have several of these ever happened during the same period of time? ☐ Yes ☐ No
33.	How much of a problem did any of these cause you – like being unable to work; having family, money or legal troubles; getting into arguments or fights? Please circle one response only. ☐ No Problem ☐ Minor Problem ☐ Moderate Problem ☐ Serious Problem

		YES	NO
34.	Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?		
35.	Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?		
36.	In the past few weeks, have you wished you were dead?		
37.	In the past few weeks, have you thought that others would be better off if you were dead?		
38.	In the past few weeks, have you had thoughts of killing yourself?		
39.	Have you ever tried to kill yourself? If yes, How? _____ When? _____		
40.	Are you having thoughts of killing yourself today?		
41.	Have you ever hurt yourself with the purpose or intention of hurting yourself but NOT with suicidal intent? If you yes, what did you do? _____		
42.	Do you have any immediate or recent thoughts of hurting others?		
43.	Are you ever afraid of your partner?		
44.	Has your partner ever screamed at you or threatened to hurt you?		
45.	Has your partner ever hit, kicked, punched, or otherwise hurt you?		
46.	Has your partner ever put you down, humiliated you, or tried to control you?		

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GENERALIZED ANXIETY DISORDER 7-ITEM SCALE (GAD-7)

Name: _____ Date of Birth: _____ MRN: _____

Over the last 2 weeks, how often have you been bothered by the following problems?	**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's 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 the score for each column		+	+	+ =	**TOTAL** _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

*Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. Arch Intern Med. 2006;166:1092-1097.