

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 AT THIS TIME or during the past six months:

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

Alabama Psychiatric Services, P.C.

Adult Patient Questionnaire

Psychiatric History (Please check all that apply)

I have received treatment for:	The treatment occurred at:	Are you presently being treated?
<input type="checkbox"/> Substance abuse	<input type="checkbox"/> Alabama Psychiatric Services Office	<input type="checkbox"/> Yes
<input type="checkbox"/> Mental health	<input type="checkbox"/> Other private psychiatrist	<input type="checkbox"/> No
<input type="checkbox"/> Both	<input type="checkbox"/> Other counseling service	If yes, by whom? _____
	<input type="checkbox"/> Mental Health Center	_____
	<input type="checkbox"/> Hospital	
	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you make yourself sick because you feel uncomfortably full?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you worry you have lost control over how much you eat?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you recently lost more than 14 pounds in a 3 month period?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you believe yourself to be fat when others say you are too thin?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Would you say that food dominates your life?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you experiencing any physical pain?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

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

<input type="checkbox"/> Neurological impairment	<input type="checkbox"/> Cirrhosis	<input type="checkbox"/> Cancer
<input type="checkbox"/> Seizure disorder	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Thyroid disease
<input type="checkbox"/> Visual loss / impairment	<input type="checkbox"/> Heart condition	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Hearing loss / impairment	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Pregnancy
<input type="checkbox"/> Dementia	<input type="checkbox"/> Asthma	<input type="checkbox"/> Irregular menstrual periods
<input type="checkbox"/> GI disorder	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Musculoskeletal condition
<input type="checkbox"/> Obesity	<input type="checkbox"/> Chronic bronchitis	<input type="checkbox"/> HIV / AIDS / Related condition
<input type="checkbox"/> Significantly underweight	<input type="checkbox"/> Tuberculosis / +PPD	<input type="checkbox"/> 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.