

Alabama Psychiatric Services, P.C.

Adult Patient Questionnaire

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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 the APS office today:

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

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| Socially withdrawn | Self induced vomiting |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

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Psychiatric History:

Please check all that apply:

I received treatment for:

Substance abuse

Mental health

Both

Are you presently being treated?

Yes ___ No ___

If yes, by whom? _____

The treatment occurred at:

Alabama Psychiatric Services Office

Other private psychiatrist

Other counseling service

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 ___

Are you experiencing any physical pain? Yes ___ No ___

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

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