

Date: _____

Patient Questionnaire

Name: _____ DOB: _____ Phone#: _____

Address: _____ Email address: _____

How would you rate your health today? Very Good Good Fair Poor

What is your chief complaint today? _____

How long have you had this problem? _____

Are you currently taking any medication? (Please including birth control and over the counter medication _____

Do you have any allergies to any medication? _____

List all hospitalization / surgical procedures you have had since your last visit: _____

Do you use:

Alcohol- Number of Years _____ Number of days per week _____
Last Drink _____

Tobacco- Number of Years _____ Packs per Day _____

Illicit Drugs- Number of Years _____ Number of days per week _____
Last Use _____

Females Only:

Last Menstrual Period: _____ Last Mammogram: _____

Last Pap Smear/Pelvic Exam: _____ # Pregnancies: _____

Office Use:

Height: _____ *Weight:* _____ *Waist* _____ *BMI* _____

Temp _____ Pulse _____ Respirations _____

Blood Pressure _____ / _____ Pulse Ox _____

Blood Sugar _____

Client Name: _____

Date of Birth: _____

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	<input type="checkbox"/> (0)	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)
2. Not being able to stop or control worrying	<input type="checkbox"/> (0)	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)
3. Worrying too much about different things	<input type="checkbox"/> (0)	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)
4. Trouble relaxing	<input type="checkbox"/> (0)	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)
5. Being so restless that it's hard to sit still	<input type="checkbox"/> (0)	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)
6. becoming easily annoyed or irritable	<input type="checkbox"/> (0)	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)
7. Feeling afraid as if something awful might happen	<input type="checkbox"/> (0)	<input type="checkbox"/> (1)	<input type="checkbox"/> (2)	<input type="checkbox"/> (3)
<i>Add the score for each column</i>	_____	_____	_____	_____
Total Score (<i>add your column scores</i>) =	_____			

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

Client Name: _____

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Patient Health Questionnaire (PHQ-9)

1. Over the <i>last 2 weeks</i> , how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
a. Little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Feeling down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Trouble falling/staying asleep, sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Feeling tired or having little energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Poor appetite or overeating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Feeling bad about yourself or that you are a failure or you have let yourself or your family down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Trouble concentrating on things, such as reading the newspaper or watching television	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Moving or speaking so slowly that other people could have noticed. Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. If you checked off any problems on this questionnaire so far, how difficult have these problems 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
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Please rate how well you have been doing in the following areas of your life:

1. Managing your day-to-day responsibilities?

- Not well at all
- Fairly well
- Moderately well
- Quite well
- Very well

2. Maintaining positive relationships with others who are important to you?

- Not well at all
- Fairly well
- Moderately well
- Quite well
- Very well

3. Being able to decrease or stop your misuse of alcohol or other drugs?

- Not well at all
- Fairly well
- Moderately well
- Quite well
- Very well
- N/A

4. Managing your stress level?

- Not well at all
- Fairly well
- Moderately well
- Quite well
- Very well

5. Learning new skills that are helpful in dealing with your problems?

- Not well at all
- Fairly well
- Moderately well
- Quite well
- Very well

Review of Systems

Name: _____

DOB: _____

Do you CURRENTLY have? (IF YES, CHECK APPROPRIATE BOXES)

GENERAL

- Fatigue
- Fever
- Weight Gain >10 pounds
- Weight Loss >10 pounds

SKIN

- Nail Changes
- New Lesions
- Rash
- Skin Color Changes

HEENT

- Double Vision
- Eye Pain
- Eye Redness
- Decreased Hearing
- Earache
- Ear Ringing
- Nose Bleeds
- Dry Mouth
- Hoarseness
- Oral Ulcers
- Sore Throat

NECK

- Neck Pain
- Swollen Glands

RESPIRATORY

- Chronic Cough
- Decreased Exercise Tolerance
- Difficulty Breathing
- Coughing Up Blood
- Sputum Production

WHEEZING

- Wheezing

BREAST

- Breast Mass
- Breast Pain
- Nipple Discharge
- Skin Changes

CARDIOVASCULAR

- Chest Pain
- Leg Pains with walking
- Leg Swelling
- Night Awakening due to trouble Breathing
- Palpitations
- Shortness of Breath

GASTROINTESTINAL

- Abdominal Pain
- Change in Bowel Habits
- Constipation
- Diarrhea
- Nausea
- Vomiting
- Rectal Bleeding/Black stools
- Trouble Swallowing

GENITOURINARY

- Vaginal Discharge
- Menstrual Irregularities
- Difficulty Starting/Stopping urinary Stream
- Painful Urination
- Change in Urinary Stream
- Increased Frequency
- Blood in Urine
- Loss of Bladder Control
- Nighttime Urination
- Urinary Retention
- Urethral Discharge
- Impotence/Erectile issues
- Penile Lesions
- Testicular Mass
- Testicular Pain

MUSCULOSKELETAL

- Decreased Range of Motion
- Joint Pain
- Joint Redness
- Joint Swelling
- Joint Stiffness
- Muscle Wasting
- Muscle Weakness
- Muscle Aches/Pains

NEUROLOGICAL

- Loss of Bowel Control
- Dizziness/Vertigo
- Headaches
- Numbness/Tingling
- Passing Out
- Seizures
- Tremor

PSYCHIATRIC

- Anxiety
- Change in Sleep
- Depression
- Hallucinations
- Suicidal Thoughts

ENDOCRINE

- Appetite Changes
- Cold Intolerance
- Increased Thirst
- Increased Urination
- Hair Changes
- Sexual Dysfunction

HEMATOLOGY

- Easy Bruising
- Enlarged Lymph
- Prolonged Bleeding

Provider Review: _____

Date: _____