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	☐ (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 Score *(add your column scores)* = _____

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: _____

Date of Birth: _____

Patient Health Questionnaire (PHQ-9)

1. 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
a. Little interest or pleasure in doing things	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless	☐	☐	☐	☐
c. Trouble falling/staying asleep, sleeping too much	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
e. Poor appetite or overeating	☐	☐	☐	☐
f. Feeling bad about yourself or that you are a failure or you have let yourself or your family down	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
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	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐
I made plans to end my life in the last 2 weeks	Yes ☐	No ☐		
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?	☐	☐	☐	☐

Client Name: _____

Date of Birth: _____

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

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:_____