DESTIN MEDICAL ARTS BLDG ● 996 AIRPORT RD ● DESTIN, FLORIDA 32541 ● (850)650-0555 VOICE ● (850)650-1955 FAX

The purpose of this questionnaire is to obtain information that will help us to work with you in addressing your concerns and in developing a treatment plan that best fits your needs. By completing these questions as fully and as accurately as you can, we will be able to offer you treatment most in the line with your reasons for coming here today. Below, write-in, select or circle the items that pertain to you.

DEMOGRAPHIC INFORMATION		**DATE:**
Name: (Last, First, M)	Sponsor's SSN:	Birth date: Age: Gender:
Address:	Home Phone:	Other Phone:

Marital Status: Single Engaged Living with Someone (How long? ____________________)

Married: (How long? ______________________) Separated: (How long? ______________________)

Divorced: (How long? _____________________) Widowed: (How long? _____________________)

Do you understand and have you signed your Confidentiality and Informed Consent Statement? YES NO

Do you have any Cultural or Religious beliefs about Mental Health Treatment, to include use of Medication?
YES NO

If yes, please state:

CHIEF COMPLAINT

Please describe the primary problem/concern for which you have come to the clinic:

What do you consider to be the top three stressors in your life?

1.	2.	3.

PSYCHOLOGICAL SYMPTOMS

Emotions: *(Select any of the following emotions that you find troublesome and/or apply to you in the last month)*

☐ Hopeless	☐ Happy	☐ Fearful	☐ Confused	☐ Excited
☐ Tense	☐ Contented	☐ Anxious	☐ Angry	☐ Energetic
☐ Distrustful	☐ Lonely	☐ Jealous	☐ Guilty	☐ Relaxed
☐ Sad	☐ Helpless	☐ Bored	☐ Frustrated	☐ Restless
				☐ Suspicious

☐ Other: *(write in)*

Behaviors: *(Select any of the following emotions that you find troublesome and/or apply to you in the last month)*

☐ Under Eating	☐ Temper Outburst	☐ Over Working	☐ Impulsiveness	☐ Isolation
☐ Vomiting	☐ Aggressive	☐ Hurting Others	☐ Increased Energy	☐ Increased Smoking
☐ Over Eating	☐ Nightmares	☐ Spending Sprees	☐ Loss of Control	☐ Fears
☐ Crying	☐ Decreased Interest	☐ Odd Behavior	☐ Social Withdrawal	☐ Flashbacks
☐ Sleeping Problems	☐ Increased Drinking	☐ Hurting Self	☐ Unable to keep job	☐ Decreased Energy
☐ Mood Altering with drugs	☐ Concentration Problems	☐ Avoiding activities places & people	☐ Taking too many Risks	

Other: *(write in)*

PHYSICAL SYMPTOMS

Select any physical symptoms listed below that were a problem for you in the last month:

☐ Sweating	☐ Dizziness	☐ Trembling/Shaking	☐ Nausea
☐ Heart Pounding	☐ Fatigue/Fainting	☐ Tic/Twitches	☐ Stomach Aches
☐ Rapid Heart Beat	☐ Vision Changes	☐ Muscle Tension	☐ Diarrhea
☐ Chest Pains	☐ Stuttering	☐ Muscle Spasms	☐ Chills/Hot Flashes
☐ Shortness of Breath	☐ Blackouts	☐ Jaw Muscle or Joint Pain	☐ Skin Problems
☐ Numbness	☐ Choking Sensations	☐ Sexual Problems	

Other: *(Write in)*

PAIN ASSESSMENT

Do you have physical problems with ongoing pain? YES NO

If so, state where your pain is located and indicate the source, if known:

On a scale of 1 to 10; Circle the number that best describes the amount of pain you are experiencing:

1	2	3	4	5	6	7	8	9	10
Slight									Severe

RISK ASSESSMENT

Are you so distressed that you wish to end your life?	YES	NO
Are you thinking about hurting or killing yourself?	YES	NO
Do you have a specific plan to end your life?	YES	NO
Have you done anything to hurt yourself or end your life?	YES	NO
Do you have any family members that have attempted or committed suicide?	YES	NO
Have you ever destroyed property on purpose?	YES	NO
In the past year, have you pushed, slapped, kicked, or punched anyone?	YES	NO
Are you so distressed that you wish to end someone else’s life?	YES	NO
Are you thinking about hurting someone or killing someone?	YES	NO
Do you have a specific plan to hurt someone or end someone else’s life?	YES	NO
Are you currently or have you in the past, heard voices telling you to hurt yourself or others?	YES	NO
Do you have access to any weapons that maybe a means to harm yourself or others?	YES	NO

MENTAL HEALTH HISTORY

Have you previously been seen for a mental health reason, in an office, clinic or hospital? YES NO
If yes, please indicate below the date(s), location(s), Inpatient/Outpatient and the diagnosis:

Date	Facility	Inpatient/Outpatient	Diagnosis

ALCOHOL/SUBSTANCE USE

Substance	Amount/Frequency	Duration of use at this level	Date of Last Use
ALCOHOL			
TOBACCO			
CAFFEINE			

Do you currently have trouble with alcohol and/or drugs? YES NO
Have you had trouble with alcohol and/or drugs in the past? YES NO
Have you been treated in the past for substance abuse? YES NO
If yes, are you actively working a recovery program? YES NO
Do you use drugs or engage in behavior that may result in HIV risk factors? YES NO

FAMILY HISTORY

Has anyone in your family had a mental or emotional problem or disorder? YES NO
(Nervous breakdown, anxiety, depression, suicide, mania, psychosis, etc.)

Any history of physical, sexual, emotional or mental abuse? YES NO

LIVING ARRANGEMENTS

Select the type of residence you live in: ☐ Temporary ☐ Dorm ☐ Apartment ☐ House

List members of your household: *Name(s) age(s), gender(s):*

NAME	AGE	SEX	NAME	AGE	SEX

NUTRITION

Are you on a special diet? YES NO
Have you had any difficulties or concerns related to food intake? YES NO
Do you feel you need a nutritional referral? YES NO

DENTAL

Do you have semi-annual dental checkups? YES NO
Do you have any dental problems? YES NO

QUALITY OF LIFE

How satisfied are you with your current life? (*Select the appropriate response below)*

☐ Very Satisfied ☐ Satisfied ☐ Dissatisfied ☐ Very Dissatisfied

If married, how satisfied would your spouse say he/she is? (*Select the appropriate response below)*

☐ Very Satisfied ☐ Satisfied ☐ Dissatisfied ☐ Very Dissatisfied

Are you now or have you been a victim of domestic violence? YES NO
If yes and if you can, explain the situation:

Are you aware of services available to victims of domestic violence? YES NO

Have your current difficulties affected your family/friends/coworkers? YES NO
If yes, explain:

Do you have problems with your work performance or boss? YES NO
If yes, explain:

Do you have any legal problems? YES NO
If so, please state:

Does spirituality play a significant role in your life? YES NO

Who/What is your support system:

MEDICAL HEALTH HISTORY

Are you allergic to anything? YES NO
If yes, please list:

Females only: Are you or is there any chance you may be pregnant? YES NO
When was your last menstrual period?

Do you have any current illnesses/medical problems/surgeries? YES NO
If yes, please list:

As an adult, have you ever had any illnesses, medical problems, seizure disorder or head trauma? YES NO
If yes, please list:

As a child, did you have any illnesses, medical problems, seizure disorder or head trauma? YES NO
If yes, please list:

LEARNING CONSIDERATIONS

Do you have any communication barriers? (*If yes, select the appropriate response below)* YES NO

If yes, please indicate:	☐ Hearing	☐ Speech	☐Vision	☐ Other:
Language Spoken:	☐ English	☐ Spanish	☐ Korean	☐ Other:
Reading Preferences:	☐ English	☐ Spanish	☐ Korean	☐ Other:

EDUCATIONAL HISTORY

What is the highest grade/level of education/schooling you have completed?

Did you have any conduct or behavioral problems? YES NO
If yes, please explain:

Was there any history of a learning disability or need for special educational services? YES NO
If so, please state:

GOALS FOR TREATMENT

What are your goals for treatment and what would you like to see change or be different?

1. ______________________________
____
2. ______________________________
____
3. ______________________________
____

Advance Directives: Have you legally documented plans for mental health care or medical treatment decisions if you are unable to make them for yourself? YES NO

If yes, where is the Advance Directive located?

INFORMED CONSENT / TREATMENT AGREEMENT

I agree to make a commitment to the treatment process. I understand this means I agree to active involvement in all aspects of treatment including:

- **O Attending sessions (or letting my provider know when I cannot make it)**
- **O Voicing my opinions, thoughts, and feelings honestly and openly, whether negative or positive**
- **O Being actively involved during sessions**
- **O Completing homework assignments**
- **O Experimenting with new behaviors and new ways of doing things**
- **O Taking medication as prescribed**
- **O Implementing my crisis response plan**

I also understand that, to a large degree, my progress depends on the amount of energy and effort I make. If it is not working, I will discuss it with my provider.

Patient's Signature: Date: