INTEGRATIVE PSYCHIATRY & PSYCHOTHERAPY

Felicity Sanders, PhD

New Patient Information:
Adult

INTEGRATIVE PSYCHIATRY & PSYCHOTHERAPY PLLC
161 MAGNOLIA SQUARE COURT • ABERDEEN NC • 910.757.0714

NEW PATIENT INFORMATION

Patient name (first, mi, last) _____

What do you prefer to be called _____

Patient street address _____

City _____ State _____ Zip _____

Date of Birth _____ Patient Age _____ Sex ____ Marital Status ___

Patient telephone (home) _____ (work) _____

(cell) _____ E-Mail (home) _____

Occupation _____ E-Mail (work) _____

Who is responsible for the bill? _____

Person to be notified in the event of an emergency:

Name _____ Phone _____

Who referred you to this practice? _____

Other psychiatrists, psychologists, or therapists that have treated the patient within the past 12 months?

1) Please describe your reasons for seeking treatment at this time. Include any important events that have lead to your decision to seek treatment at this time.

2) List other counseling, therapy, or psychiatric treatment that you have had, including during your childhood.

3) List other family members who have received mental health treatment and why they have been treated.

4) List all marriages and dates.

5) List all children and their ages.

6) List all jobs that you have had and the dates.

7) Have you ever been fired? If so, why?

8) Do you have a criminal record? If yes, for what offense?

9) Did you graduate from high school?

College?

10) How were your grades in school?

11) Have you ever failed a grade or been in special classes?

12) What health problems have you had?

13) What medications are you taking?

14) What were/are your parents occupations?

15) Describe you parents' relationship with each other.

16) Describe your relationship with each parent.

17) Please list all your brothers and sisters and their ages.

18) Who are you currently living with?

19) Have you ever been physically or sexually abused or assaulted?

20) Describe your drinking or drug use.

21) Do you feel able and willing to benefit from psychological therapy at this time? Why or why not?

22) Do your friends and family agree with your decision to seek treatment at this time?

23) What are your leisure activities?

24) Are you involved in a church? If so, which faith and what is your involvement?

25) Have you ever had thoughts of ending your life or attempted to end your life?

26) Have you ever intentionally hurt yourself (e.g., cutting or hitting self)?

27) Please note anything else that your therapist should know.

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. 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	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, 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**
☐	☐	☐	☐

INTEGRATIVE PSYCHIATRY & PSYCHOTHERAPY PLLC
161 MAGNOLIA SQUARE COURT • ABERDEEN NC • 910.757.0714

Mood Disorder Questionnaire

Patient Name _____ Date of Visit _____

Please answer each question to the best of your ability

1. Has there ever been a period of time when you were not your usual self and...	**YES**	**NO**
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	☐	☐
...you were so irritable that you shouted at people or started fights or arguments?	☐	☐
...you felt much more self-confident than usual?	☐	☐
...you got much less sleep than usual and found that you didn't really miss it?	☐	☐
...you were more talkative or spoke much faster than usual?	☐	☐
...thoughts raced through your head or you couldn't slow your mind down?	☐	☐
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	☐	☐
...you had more energy than usual?	☐	☐
...you were much more active or did many more things than usual?	☐	☐
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	☐	☐
...you were much more interested in sex than usual?	☐	☐
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	☐	☐
...spending money got you or your family in trouble?	☐	☐
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	☐	☐

3. How much of a problem did any of these cause you - like being unable to work; having family, money or legal troubles; getting into arguments or fights?

☐ No problems ☐ Minor problem ☐ Moderate problem ☐ Serious problem

This instrument is designed for screening purposes only and not to be used as a diagnostic tool.
Permission for use granted by RMA Hirschfeld, MD

Alcohol screening questionnaire (AUDIT)

Our clinic asks all patients about alcohol use at least once a year. Drinking alcohol can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

Patient name: _____

Date of birth: _____

One drink equals:  12 oz. beer  5 oz. wine  1.5 oz. liquor (one shot)

1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times a month	2 - 3 times a week	4 or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	0 - 2	3 or 4	5 or 6	7 - 9	10 or more
3. How often do you have four or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, in the last year
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, in the last year
	0	1	2	3	4

Have you ever been in treatment for an alcohol problem? ☐ Never ☐ Currently ☐ In the past