Northland College
NEW PATIENT INFORMATION QUESTIONNAIRE

Name_____ Date_____
First Middle Last

Please help by completing as much of this form as you can, describing yourself. This information is important to help understand your concerns.

Date of birth_____ Age_____

REASON FOR APPOINTMENT:
Briefly—What troubles are you having that are causing you to seek services?
_____
_____
_____
Did someone refer you?
_____No _____Yes (who & why?)_____
_____

CURRENT LIFE SITUATION:
What is your current relationship status?
_____
What year are you in school? What is your major?
_____
Are you currently **employed**?
_____No _____Yes (Where? For how long?)_____

PROBLEMS AND CONCERNS:
What major stresses or changes have occurred in your life in the past 2 years? (moves, school, job change, divorce, deaths, etc.)_____
_____
How would you estimate your **current level of life stress**?
_____Low _____Medium _____High _____Manageable _____Difficult to manage
In general, have your symptoms been
_____ Staying about the same _____ Getting worse _____ Coming and going (intermittent)
_____ Other: _____

Your current concerns (check all that apply):

	How long have you had this problem?
___Depressed mood	_____
___Sleep problems	_____
___Appetite/weight change	_____
___Concentration problems	_____
___Memory problems	_____
___Low motivation	_____
___Reduced interest/enjoyment	_____
___Roommate Problems	_____
___Self-criticism/guilt	_____

___Crying spells _____
___Suicidal thoughts _____
___Self-injury behavior _____
___Mood swings _____
___Too much energy _____
___Racing thoughts _____
___Irritability _____
___Anger management problems _____
___Thoughts of harming others _____
___Seeing/hearing/smelling/feeling
things that are not really there _____
___Relationship problems _____
___Hyperactivity _____
___Aggressive behaviors _____
___Stealing _____
___Lying _____
___Vomiting after eating _____
___Self-starving _____
___Severe overeating episodes _____
___Anxiety/worry _____
___Anxiety around other people _____
___Panic attacks _____
___"Butterflies" in stomach _____
___Fast or unusual heartbeat _____
___Breathing difficulty _____
___Dizziness/lightheadedness _____
___Tingling in hands/feet _____
___"Rubbery"/shaky legs _____
___Phobias/fears _____
___Obsessions (unwanted thoughts) _____
___Compulsions (unwanted behavior) _____
___Nightmares _____
___Flashbacks _____
___Sexual problems/concerns/issues _____
___Sexual identity problems/concerns _____
___Other problems:_____

Have you ever **heard voices or seen things** that other people do not see or hear?
_____ No _____Yes (describe) _____
_____
Have you **ever tasted, felt or smelled things** that others think are not there?
_____ No _____Yes (describe) _____
_____

Have you every believed that others were **controlling your thoughts, plotting against you or that you have special powers**?
_____ No _____Yes (describe) _____
_____

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How well do you usually **sleep**? (Check all that apply.)
_____I usually fall asleep, sleep through the night and feel rested the next day.
_____I have problems falling asleep.
_____I wake up during the night and have trouble falling back to sleep.
_____I find myself waking up early in the morning (before I want to).
_____I have nightmares or bad dreams.
_____I am told that I snore.
_____I am told that I talk in my sleep.
_____I sleepwalk.
_____I often nap during the day.
_____I get _____hours of sleep on average.
_____I work rotating shifts.
_____I sleep during the day, and am awake at night.

TRAUMA EXPOSURE:
Have you experienced **physical, sexual or emotional abuse or neglect** at any time in your life?
_____No _____Yes (How old were you?) _____(by whom) _____
_____ _____
Have you experienced any other traumatic event during your life?
_____No _____Yes (describe)_____
_____

RISK ASSESSMENT:
Have you ever tried to **end your life**?
_____No _____Yes (When? How?) _____
_____
Have you ever hurt yourself on purpose, not to die but to feel better?
_____No _____Yes (How? Most recent episode?) _____
_____
Do you have friends or family members who have committed suicide?
_____No _____Yes (who? When?) _____
_____

How would you describe your **temper**?
_____Good control
_____Moderate control
_____I have frequent anger flare-ups.

Did you get into physical fights as a child/teenager? ___Yes ___No
If Yes, how often?_____
If Yes, were you ever in a juvenile detention facility for fighting? ___Yes ___No
When was the last time you were in a physical fight? ___
Have you ever been charged with any kind of "assault?" ___Yes ___No
Have you ever been convicted of any kind of assault? ___Yes ___No
Have you ever had serious thoughts to hurt or kill another person? ___Yes ___No
Are you having thoughts today about hurting are killing another person? ___Yes ___No

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SUBSTANCE USE SCREENING ASSESSMENT

CAGE-AID

1. Have you ever felt you ought to cut down on your drinking or drug use? ☐Y ☐ N
2. Have people annoyed you by criticizing your drinking or drug use? ☐Y ☐ N
3. Have you felt bad or guilty about your drinking or drug use? ☐Y ☐ N
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)? ☐Y ☐ N

SUBSTANCE USE/ADDICTIVE BEHAVIORS:

	Age of first use	Last use	How often do you use	Amount used	How ingested	Longest abstinence	Current craving to use?	Time of heaviest use	How long did this last?
Alcohol									
Marijuana									
Cocaine									
Amphetamines									
Inhalants									
Hallucinogens									
Opiates									
Benzodiazepines									
Nicotine									
Other									

Have you attended Alcoholics Anonymous or Narcotics Anonymous Meetings?

_____No _____Yes (how often?) _____Do you have a sponsor? _____No ____Yes

Does your alcohol or drug use lead to: (check all that may apply)

_____work problems _____school problems _____health problems

_____legal problems _____family/social problems

Have you participated in chemical dependency treatment?

Inpatient (where, when)

_____

Outpatient (where, when)

_____

Do you feel you have a problem with gambling?.....Yes No

Have you ever had financial problems due to gambling?.....Yes No

Do you engage in any other behaviors in an addictive way?.....Yes No

If yes please list_____

STRENGTHS & INTERESTS:

What are your hobbies and recreational interests?_____

_____

_____

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What are your strengths?_____
_____

MENTAL HEALTH CARE HISTORY:

Have you had previous mental health services? If so, when? By whom?

Psychiatric care_____
Psychotherapy _____
Mental health hospitalization_____
Partial hospitalization program_____
Psychological testing_____
Other:_____

Do you have current mental health providers (Psychiatrist, Psychiatric NP, therapist)
_____No _____Yes (who?)_____
Have you been diagnosed with a mental illness/mental health problem?
_____No _____Yes (list)_____

Have you taken other mental health medicines in the past or are you currently taking mental health medicines?
_____ No
_____ Yes:

Name of medication	Helpful/negative effects	Who is Prescribing?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICAL HISTORY:

Primary care provider_____
Primary care provider's office location_____
Do you have current significant medical conditions/physical health symptoms, or are you concerned about possible medical conditions or physical health symptoms?
_____No _____Yes (explain)_____
_____
_____
Are you taking medicines now for physical health problems?
_____No _____Yes: (What? Who is prescribing?)_____
_____
Have you had past significant medical problems or hospitalizations?
_____No _____Yes (What? When?) _____
_____

FAMILY OF ORIGIN/SOCIAL HISTORY:

Relational status ***of your parents*** as you were growing up:
____Married ____Domestic Partner ____Never lived with one another
____Separated (How old were you?_____) ____Divorced (How old were you?_____)
____Widowed (Which parent died?_____) How old were you?_____)

Who raised you? _____Both parents _____Other_____
How many brothers and sisters do you have?_____
What is your birth order among your siblings?_____

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FAMILY BACKGROUND:
Where were you born?_____
Where were you raised?_____
Do you recall your childhood as ____happy or ___stressful?
FAMILY MENTAL HEALTH HISTORY:
Are any of your **biological relatives**,(i.e. parents, siblings, grandparents, aunts, uncles or cousins) diagnosed with the following conditions? (check all that apply and indicate which family member or members have this diagnosis)

_____Depression
_____Bipolar disorder
_____Anxiety disorders
_____Schizophrenia
_____Alcohol abuse/dependence
_____ADHD/ADD
_____Learning disorder
_____Autism or autistic spectrum disorder
_____Eating disorder
_____Tic or Tourette's disorder
_____Dementia
_____Thyroid problems
_____Other:

EDUCATIONAL/EMPLOYMENT/MILITARY HISTORY:
Did you have any of the following at school as a child/teenager?
_____Special education support (for what)_____
_____Low grades _____Suspended or expelled _____Social problems _____Difficulties reading or writing
_____Other _____

SOCIAL SERVICE/LEGAL HISTORY:
Were you ever in foster placement?
_____No _____Yes (ages?_____)
Do you have any history of significant **legal** problems?
_____No _____Yes (please list offenses, dates, and consequences—jail, fines, probation, etc)
_____

CULTURAL CONSIDERATIONS:
Are you actively involved in church, religious activities or cultural activities?
_____No _____Yes (describe) _____
_____
How do you identify your gender?
_____
How would you describe your sexual orientation?
___Heterosexual ___Gay/Lesbian ___Bisexual
___Other (describe)_____
How would you describe your/your family's income?
___low ___middle ___high
How would you describe your race/ethnic heritage?_____
Is there any additional important information that you want us to know?
_____
_____
_____
_____