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New Patient Questionnaire

Thank you for trusting San Francisco Psychiatry with your psychiatric care!

Kindly complete this form and return it via fax, email or electronically. If you prefer to skip a question or to instead discuss it during your office visit, please feel free to do so.

Name _____
Today's Date_____
Date of Birth_____
Primary Care Physician and Phone_____
Do you give permission for ongoing regular updates to be provided to your primary care physician? _____
Current Therapist and Phone _____
Do you give permission for us to speak with your therapist? _____
Prior Psychiatrist and Phone _____
Do you give permission for us to speak with your psychiatrist? _____
What is/are the problem(s) for which you are seeking help?
1._____
2._____
3._____
What are your treatment goals? _____

Current Symptoms Checklist (check once for any symptoms present, twice for major symptoms):

( ) Depressed mood	( ) Racing thoughts	( ) Excessive worry
( ) Unable to enjoy activities	( ) Impulsivity	( ) Anxiety attacks
( ) Sleep pattern disturbance	( ) Increased risky behavior	( ) Avoidance
( ) Loss of interest	( ) Fatigue	( ) Hallucinations
( ) Concentration/forgetfulness	( ) Decreased need for sleep	( ) Suspiciousness
( ) Change in appetite	( ) Excessive energy	( ) Excessive guilt
( ) Decreased libido	( ) Excessive irritability	( ) _____
( ) Increased libido	( ) Crying spells	

Suicide Risk Assessment:
Have you ever had feelings or thoughts that you didn't want to live? ( ) Yes ( ) No.
If YES, please answer the following. If NO, please skip to the next section.
Do you **currently** feel that you don't want to live? ( ) Yes ( ) No
How often do you have these thoughts? _____
When was the last time you had thoughts of dying? _____
Has anything happened to make you feel this way? _____
How strong is your desire to end your life (1-10 scale, with 10 being strongest) _____
Have you come up with a specific plan?_____
Access to guns? _____

Past Medical History:

Allergies to Medication? _____

List ALL current prescription medications and how often you take them: (**if none, write none**)

Medication Dosage Estimated Start Date

_____

_____

_____

_____

_____

_____

Current over-the-counter (OTC) medications or supplements: _____

Current medical problems: _____

Past medical problems, non-psychiatric hospitalization, or surgeries: _____

Have you ever had an EKG? ( ) Yes ( ) No. If yes, when _____

Was the EKG ( ) normal ( ) abnormal or ( ) unknown?

Women only:

Are you currently pregnant or do you think you might be pregnant? ( ) Yes ( ) No.

Are you planning to get pregnant in the near future? ( ) Yes ( ) No

Personal Medical History:

Please mark if you have any of the following conditions.

____Thyroid Disease
____Anemia
____Liver Disease
____Chronic Fatigue
____Kidney Disease
____Diabetes
____Asthma/Respiratory Problems
____Stomach/GI Problems
____Cancer (please specify type: _____)
____Fibromyalgia
____Heart Disease
____Epilepsy/Seizures
____Chronic Pain
____High Cholesterol
____High Blood Pressure
____Head Trauma
____Liver Problems
____Other Significant Medical Issue(s) (please specify: _____)

Family Medical History:

Is there any additional personal or family medical history? ( ) Yes ( ) No If yes, please explain:

_____

_____

When your mother was pregnant with you, were there any complications during the pregnancy or birth?

_____

Past Psychiatric History:

Outpatient treatment ( ) Yes ( ) No. If yes, Please describe when, by whom, and nature of treatment.

Reason Dates Treated By Whom

_____

_____

Psychiatric Hospitalization ( ) Yes ( ) No. If yes, describe for what reason, when and where.

Reason Date Hospitalized Where

_____

_____

Past Psychiatric Medications: If you have ever taken any of the following medications, please indicate the dates, dosage, and how helpful they were (if you can't remember all the details, just write in what you do remember).

Antidepressants/Antianxiety **Dates** **Dosage** **Response/Side-Effects**

SSRIs :

Prozac (fluoxetine) _____

Zoloft (sertraline) _____

Luvox (fluvoxamine) _____

Paxil (paroxetine) _____

Celexa (citalopram) _____

Lexapro (escitalopram) _____

SMSs:

Viibryd (vilazodone) _____

Trintellix (vortioxetine) _____

SNRIs:

Effexor (venlafaxine) _____

Cymbalta (duloxetine) _____

Pristiq (desvenlafaxine) _____

NDRIs:

Wellbutrin (bupropion) _____

NSRIs:

Fetzima (levomilnacipran) _____

NaSSAs:

Remeron (mirtazapine) _____

TCAs:

Anafranil (clomipramine) _____

Elavil (amitriptyline) _____

Other _____

Mood Stabilizers (for Bipolar Disorder)

Lithium _____

Depakote (valproate) _____

Lamictal (lamotrigine) _____

Tegretol (carbamazepine) _____

Trileptal (oxcarbazepine) _____

Topamax (topiramate) _____

Other _____

Antipsychotics

Seroquel (quetiapine) _____

Zyprexa (olanzapine) _____

Geodon (ziprasidone) _____

Abilify (aripiprazole) _____

Invega (paliperidone) _____
Clozaril (clozapine) _____
Haldol (haloperidol) _____
Prolixin (fluphenazine) _____
Risperdal (risperidone) _____
Latuda (lurasidone) _____
Saphris (asenapine) _____
Fanapt (iloperidone) _____
Rexulti (brexpiprazole) _____
Vraylar (cariprazine) _____
Other _____

Sedatives/Hypnotics
Ambien (zolpidem) _____
Sonata (zaleplon) _____
Lunesta (eszopiclone) _____
Rozerem (ramelteon) _____
Restoril (temazepam) _____
Trazodone _____
Belsomra (suvorexant) _____
Other _____

Stimulants/ADD Meds
NRIs:
Strattera (atomoxetine) _____
Methylphenidates:
Ritalin (methylphenidate) _____
Concerta (long-acting methylphenidate) _____
Amphetamines:
Adderall (amphetamine) _____
Dexedrine (dextroamphetamine) _____
Vyvanse (lisdexamfetamine) _____
Other _____

Antianxiety
Benzodiazepines:
Klonopin (clonazepam) _____
Xanax (alprazolam) _____
Ativan (lorazepam) _____
Valium (diazepam) _____
5-HT$_{1A}$ Partial agonist:
Buspar (buspirone) _____
Other _____

Family Psychiatric History:
Place a check mark if anyone in your family has been diagnosed with or treated for any of these conditions:
___Bipolar disorder
___Schizophrenia
___Depression
___PTSD
___Anxiety
___Alcohol Abuse
___Other Substance Abuse
___Suicide

If yes, who had each problem? _____
Has any family member been treated with a psychiatric medication? ( ) Yes ( ) No.
If yes, who was treated, what medications did they take, and how effective was the treatment? _____
_____

Substance Use:
Have you ever been treated for alcohol or drug use or abuse? ( ) Yes ( ) No
If yes, for which substances? _____
If yes, where were you treated and when? _____
How many days per week do you drink any alcohol? _____
In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day? _____
Have you ever felt you ought to cut down on your drinking or drug use? ( ) Yes ( ) No
Do you think you may have a problem with alcohol or drug use? ( ) Yes ( ) No
Have you used any street drugs in the past 3 months? ( ) Yes ( ) No
If yes, which ones? _____
Have you ever abused prescription medication? ( ) Yes ( ) No
If yes, which ones and for how long? _____

Tobacco History:
How you ever smoked cigarettes? ( ) Yes ( ) No
Currently? ( ) Yes ( ) No How many packs per day on average? _____ How many years? _____
In the past? ( ) Yes ( ) No How many years did you smoke? _____ When did you quit? _____

Educational History:
What is your highest level of education? _____

Occupational History:
Are you currently: ( ) Working ( ) Student ( ) Unemployed ( ) Disabled ( ) Retired
What is/was your occupation and for how long? _____
Where do you work? _____
Have you ever served in the military? _____ If so, what branch and when? _____
Honorable discharge ( ) Yes ( ) No Other type discharge? _____

Relationship History and Current Family:
Are you currently in a relationship? ( ) Yes ( ) No If yes, how long? _____
What is your spouse or significant other's occupation? _____
Do you have children? ( ) Yes ( ) No If yes, list ages and gender: _____
List everyone who currently lives with you: _____

Legal History:
Have you ever been arrested? _____
Do you have any pending legal problems? _____

Patient Signature _____ Date _____

Guardian Signature (if applicable) _____ Date _____

Emergency Contact _____ Telephone # _____