The Evergreen Clinic
New Patient Health Information

The purpose of this questionnaire is to help ensure your first visit to our office is as productive as possible. Please answer the following questions and items as completely and honestly as you can. Information provided here will help in your care and treatment.

Today's Date	**Patient Date of Birth**
Patient Name	

Please list your healthcare providers, other than your primary care physicians

Provider Name	**Provider Phone Number**	**Type of Treatment Office and Nature of Concern**

Please list any past or present psychiatric treatment, counseling, psychotherapy, family therapy, or chemical dependency treatment, including hospitalization.

Dates of Service	**Provider Name and Office Name**	**Type of Treatment**

Please list any medications for psychiatric condition that you are currently taking or have taken in the past.

Medication and Dosage	**Date Started**	**Reason for Taking This Medication**	**Results**

Please list any other medications you are taking.

Medication and Dosage	**Date Started**	**Reason for Taking This Medication**	**Results**

Please list and describe any allergies and medications reactions you have had.

_____

_____

_____

Past and Present Substance Use

Substance Form	**Frequency of Use**	**Quantity of Use**	**Purpose of Use**
Caffeine			
Tobacco			
Marijuana			
Sedatives / Sleeping Pills (Valium, Xanax, Klonipin, Barbituates, etc)			
Alcohol (beer, wine, etc)			
Hallucinogens (LSD, Mushrooms, etc)			
Cocaine (including crack)			
Amphetamines			
Opioids – prescribed or not (Morphine, Heroin, etc)			

	Yes	No	When
Have you ever been cited for an alcohol or drug related offense?	___	___	_____
Have you ever felt bad or guilty about your alcohol or drug use?	___	___	_____
Have you ever deliberately reduced your alcohol or drug use?	___	___	_____
Have you ever used alcohol or drugs in the morning?	___	___	_____
Have others annoyed you with their concerns about your alcohol or drug use?	___	___	_____
Have you ever had a "blackout" from drugs or alcohol (not passing out)?	___	___	_____

Please indicate if you are experiencing any of the problems listed here. Indicate if they are **Absent**, **Mild**, **Moderate**, or **Severe** and how long you have had the problem.

	Absent	Mild	Moderate	Severe
Anxiety				
Compelled to Repetitive Behavior				
Decreased Sex Drive				
Difficulty Concentrating / Focusing				
Easy Crying				
Excess Energy / Agitation				
Hallucinations (hearing or seeing things that may not be there)				
Impulsive Decision Making				
Increased Sex Drive				
Irritability				
Low Energy				
Mind Racing				
Non-Suicidal Self-Harm (When and How)				
Panic (time limited, overwhelming)				
Reduced Enjoyment/Interest				
Sad of Flat Mood				
Slow Thinking				
Social Withdrawal				
Suicidal Thoughts / Impulses / Plans				
Suicide Attempts (When and How)				
Talking Fast or Often				
Thoughts of Hurting Others				
Trouble Making Decisions				
Violence to Others (When and How)				
Vomiting or Laxatives for Weight Loss				
Nightmares				
Frequent Fear				
Insomnia (lack of sleep) or Hypersomnia (excessive sleep)				
Loss of appetite or increased appetite				
Intrusive Thoughts				

Trauma History

Have you ever been physically abused: ___ Yes ___ No

If yes, by whom: _____

If yes, at what age(s): _____

Have you ever been sexually abused: ____ Yes ____ No

If yes, by whom: _____

If yes, at what age(s): _____

Have you experienced any other accidents or other instances that you would consider traumatic: ___ Yes ___ No

If yes, please explain: _____

_____

Do you have any current significant life stressors, such as financial difficulty, loss/change of employment, death of a loved one, recent change of housing, divorce, or other?

_____

_____

_____

Do you have any current or past legal issues, such as arrests, convictions, imprisonments, probation, or other legal problems?

_____

_____

_____