THE EVERGREEN CLINIC
NEW PATIENT HEALTH INFORMATION

The purpose of this questionnaire is to make the first visit more useful to you, both by providing information needed for your care as well as by helping you participate in your treatment. Please answer the following as completely as you can.

Date: ____________________

Name: ____

Reason For Referral: ____

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Your current healthcare providers, other than your primary care physician:

Name:	**Phone Number**	**Nature of Problem/Type of Treatment**

Current and Past Mental Health Treatment

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

Dates:	**Clinician Name & Degree/Hospital Name**	**Type of Treatment**

List any medications for a psychiatric or nervous condition that you are currently on or have taken in the past.

Date Started	Medication and Dose	Reason For Taking	Results

List any other medications you are on.

Date Started	Medication and Dose	Reason for Taking

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

Presenting Problems: Please state whether it is **absent, mild, moderate** or **severe** and how long you've had the problem.

Sad or Flat Mood: ____
Slowed Thinking: ____
Trouble Making Decisions: ____
Reduced enjoyment/interest: ____
Easy Crying: ____
Low Energy: ____
Decreased Sex Drive: ____
Social Withdrawal: ____
Elevated or Giddy Mood: ____
Irritability: ____
Mind Racing: ____
Impulsive decision-making: ____
Talking fast or a lot: ____
Excess Energy/Agitation: ____
Increased Sex Drive: ____
Anxiety: ____
Panic (time limited, overwhelming): _____________________________________
Compelled to do something repeatedly: ___________________________________
Hallucinations (hearing or seeing things that may not be there): _______________________
Difficulty concentrating/focusing: _______________________________________
Suicidal Thoughts/Impulses/Plans: _______________________________________
Suicide attempts – when, how: ____
Non-Suicidal self-harm-when, how: _______________________________________
Thoughts of hurting others: ____
Violence to others – when, how: ____
Vomiting or laxatives for weight loss: ____________________________________

Past & Present Substance Use

Substance and Form	How Often	Amount of Each Use	Use
Caffeine			
Tobacco			
Sedatives and sleeping Pills (Valium, Xanax, Klonipin, Barbituates, Etc…)			
Alcohol (Beer, Wine, Liquor)			

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 cut back deliberately on you alcohol or drug use?
___ ___ _______Have you used alcohol or drugs in the morning?
___ ___ _______Have others annoyed you with their talk about your alcohol or drug use?
___ ___ _______Have you ever had a "blackout" from drugs or alcohol(not passing out)?

Trauma History

Sexually or physically abused: ( ) Yes ( )No If Yes:
By Whom: ____
At What Age: ____

Experienced war or natural disaster: ( )Yes ( )No If Yes:
Nature of Experience: ____
When: ____

Legal History

(Arrests, convictions, imprisonment, probation, current legal problems)

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Reviewed By_______