Stone Creek Psychiatry
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NEW PATIENT PACKET

INITIAL EVALUATION

Initial Evaluation Date: _____

Patient Name: _____ Date of Birth: _____

Martial Status: _____ M _____ S _____Partnered _____ Widow _____ Divorced _____ years

Race: _____ Number of Children: _____

Current Residence: _____ City: _____ State: _____ Zip: _____

Primary Care Physician: _____

Psychiatric Providers (Current/Past) : _____

Therapists (Current/Past) : _____

CHIEF COMPLAINT: (Briefly describe the current symptoms/stressors you are currently experiencing. Why are you seeking psychiatric services?)

_____

_____

_____

CURRENT SYMPTOMS: (How are you feeling now? Depressed, Anxious, Agitated, Angry, Irritable, Tired, Not sleeping, Hopeless, Overwhelmed, Suicidal, etc.…)

_____

_____

_____

PAST PSYCHIATRIC DIAGNOSES: (What were you being treated for in the past?) Please check mark all that apply**:** _____ Depression _____ Bipolar _____ Schizophrenia _____ADHD _____PTSD _____Panic Attacks _____ Schizo-Affective Disorder _____Insomnia _____Obsessive-Compulsive Disorder _____Addiction _____ Eating disorder _____Borderline Personality

Other:_____

PAST PSYCHIATRIC HISTORY: Please list names/dates of any: Hospitalizations/ Psychiatric Treatment History/ Commitments/ Self injury/ Suicide attempts

_____

_____

_____

CURRENT PSYCHOTROPIC MEDICATIONS: (Please list name, dosage, frequency taken)

_____

_____

_____

PAST PSYCHOTROPIC/MEDICATIONS TRIED: (Check mark ones tried previously)

Anti-depressants: _____ Prozac _____ Zoloft _____ Celexa _____ Wellbutrin _____Effexor _____Cymbalta _____ Remeron, Other _____

Mood Stabilizers: _____ Lithium _____ Depakote, _____ Lamictal, Other _____

Antipsychotics: _____ Seroquel _____ Zyprexa _____Abilify _____ Risperidone, Other_____

Sedatives: _____ Xanax _____ Ativan _____ Clonazepam _____Buspar, Other_____

Sleep: _____ Ambien _____ Trazodone _____Lunesta, Other _____

ADHD: _____ Stimulants _____Adderall _____Ritalin _____ Vyvanse AND/OR Non-Stimulants _____Strattera, Other _____

If application were there any side effects from previously prescribed medications?

_____

_____

_____

CHEMICAL HEALTH HISTORY

Age of onset drug/alcohol use: _____

Please list **age of onset and frequency of use** for each chemical listed below. Leave blank if no use:

Alcohol: _____

Marijuana/Synthetic Marijuana (K2): _____

Amphetamines/Cocaine: _____

Opiates/Prescription/Illegal/Heroin: _____

Sedatives/Benzodiazepines: _____

Hallucinogens/LSD/Mushrooms: _____

PCP/Ecstasy/Ketamine: _____

IV Drug Use (Frequency and Drug): _____

Nicotine: _____

Caffeine: _____

Previous CD Treatment: (When and Where/Drug of Choice):

_____

_____

_____

Have you ever been concerned about your drug use? _____ Y _____ N

Other: _____

Has anyone, including a family member, friend, or healthcare provider been concerned about your drug use or suggested you cut down? _____ Y _____ N Other: _____

Consequences of Use:

Loss of employment: _____

Loss of relationships: _____

Pending Legal Issues: _____

Any DWIs: _____ Y _____ N, If yes, date(s): _____

License Returned _____ Y _____ N

FAMILY PSYCHIATRIC HISTORY:

Please list any family members (mother, father, paternal/maternal aunts, uncles, grandparents, etc) where applicable, otherwise leave blank. Please list each relative for every disease that applies.

Depressions: _____

Anxiety/Panic: _____

Bipolar: _____

ADHD: _____

Low IQ/Learning Disability: _____

Suicide Attempts: _____

Dementia/Alzheimer's _____

Schizophrenia: _____

Alcohol Dependency: _____

Illegal Drug/Prescription Abuse: _____

SOCIAL HISTORY:

Where were you born and raised? _____

How many siblings did you have growing up? _____ Where were you in Birth order? _____

Were you adopted? _____ If yes, how old were you? _____

Did you grow up with both parents? _____ If not, how old were you when they separated? _____

What was it like growing up? Were your parents supportive? Abusive? Neglectful?

_____

_____

_____

SIGNIGICANT LIFE EVENTS (Traumatic or Other):

Physical: _____

Sexual/Rape: _____

Emotional/Verbal: _____

Deaths/Illnesses: _____

Other: _____

EDUCATION AND WORK HISTORY:

Highest level of education complete: _____ High School (_____ years) _____GED _____College (_____ years) _____ Vocational (_____ years) _____ graduate degree (_____ years)

Occupational History: _____ Full-time _____ Part-time _____ Unemployed _____ Retired Disability: _____ Last worked: _____ Type of Work: _____

Length employed: _____ Spouse or Partner Employment: _____

Living Situation: _____ House _____ Townhome _____Apartment _____ With parents _____ Group home _____ Assisted Living _____ Homeless

CURRENT STRESSORS:

Financial Status/Stressors

(Current/Past): _____

_____

_____

Legal Issues

(Divorce / Bankruptcy / Criminal Charges): _____

_____

_____

(Legal Guardian / Conservator / Power of Attorney / PO Officer) If Applicable: _____

_____

Loss of Employment (When/how): _____

_____

Moving: _____

Death of Friend/Family Member: _____

MILITARY SERVICE HISTORY: _____ None _____ Army _____ Navy _____ Air Force _____ Marines _____ Length of time

REVIEW OF SYMPTOMS: Please check mark all that apply

Any current physical complaints: _____ Headaches _____ Stomach aches _____Shortness of breath _____Cough _____ Recent loss of taste or smell _____Fatigue _____ Lack of energy _____ Fever _____Chills _____ Physical aches or pains _____ Back pain _____Painful joints _____ Recent Infections _____ Colds or flu _____ Unexplained weight gain or weight loss _____ Loss of appetite _____ Problems urinating _____Rashes or itching _____ Teeth problems _____ Visual problems

Medical Conditions (High Blood Pressure, Diabetes, Heart Disease, etc): _____

_____

_____

_____

Head Trauma/Concussions/Seizures: _____

_____

_____

If female, are you pregnant or possibility of pregnancy? _____ Yes _____ No

OTHER CURRENT MEDICATIONS: _____

_____

_____

MEDICATION ALLERGIES: _____

_____

_____

Burn's Depression Checklist

Name: Date:

Instructions: Put a check ☑ to indicate how much you have experienced each symptom during the past week, including today. Please answer all 25 items.		0 = Not At All	1 = Somewhat	2 = Moderately	3 = A Lot	4 = Extremely
Thoughts and Feelings						
1	Feeling sad or down in the dumps					
2	Feeling unhappy or blue					
3	Crying spells or tearfulness					
4	Feeling discouraged					
5	Feeling hopeless					
6	Low self-esteem					
7	Feeling worthless or inadequate					
8	Guilt or shame					
9	Criticizing yourself or blaming others					
10	Difficulty making decisions					
Activities and Personal Relationships						
11	Loss of interest in family, friends or colleagues					
12	Loneliness					
13	Spending less time with family or friends					
14	Loss of motivation					
15	Loss of interest in work or other activities					
16	Avoiding work or other activities					
17	Loss of pleasure or satisfaction in life					
Physical Symptoms						
18	Feeling tired					
19	Difficulty sleeping or sleeping too much					
20	Decreased or increased appetite					
21	Loss of interest in sex					
22	Worrying about your health					
Suicidal Urges						
23	Do you have any suicidal thoughts?					
24	Would you like to end your life?					
25	Do you have a plan for harming yourself?					
	Please Total Your Score on Items 1-25 Here:					

Total Score	Level of Depression
No Depression	0-5
Normal but unhappy	6-10
Mild depression	11-25
Moderate depression	26-50
Severe depression	51-75
Extreme depression	76-100

The Burns Anxiety Inventory

Place a check mark in the box to the right of each category to indicate how much this type of feeling has bothered you in the past several days.

Category I: Anxious Feelings	**0 Not at all**	**1 Somewhat**	**2 Moderately**	**3 A Lot**
1. Anxiety, nervousness, worry or fear				
2. Feeling that things around you are strange or unreal				
3. Feeling detached from all or part of your body				
4. Sudden unexpected panic spells				
5. Apprehension or a sense of impending doom				
6. Feeling tense, stressed, "uptight" or on edge				
Category II: Anxious Thoughts	**0 Not at all**	**1 Somewhat**	**2 Moderately**	**3 A Lot**
7. Difficulty concentrating				
8. Racing thoughts				
9. Frightening thoughts				
10. Feeling that you're on the verge of losing control				
11. Fears of cracking up or going crazy				
12. Fears of fainting or passing out				
13. Fears of physical illnesses or heart attacks or dying				
14. Concerns about looking foolish or inadequate				
15. Fears of being alone, isolated, or abandoned				
16. Fears of criticism or disapproval				
17. Fears that something terrible is about to happen				

Category III: Physical Symptoms	**0 Not at all**	**1 Somewhat**	**2 Moderately**	**3 A lot**
18. Skipping, racing or pounding of the heart (palpitations)				
19. Pain, pressure, or tightness in chest				
20. Tingling or numbness of toes and fingers				
21. Butterflies or discomfort in the stomach				
22. Constipation or diarrhea				
23. Restlessness or jumpiness				
24. Tight, tense muscles				
25. Sweating not brought on by heat				
26. A lump in the throat				
27. Trembling or shaking				
28. Rubbery or "jelly" legs				
29. Feeling dizzy, lightheaded or off balance				
30. Choking or smothering sensations or difficulty breathing				
31. Headaches or pains in the neck or back				
32. Hot flashes or cold chills				
33. Feeling tired, weak, or easily exhausted				
Total score on items 1-33				

Mood Disorder Questionnaire

Stable Resource Toolkit

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

Patient Health Questionnaire (PHQ-9)

	Not at all	Several days	More than half the days	Nearly every day
1. Over the *last 2 weeks,* how often have you been bothered by any of the following problems?				
a. Little interest or pleasure in doing things	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless	☐	☐	☐	☐
c. Trouble falling/staying asleep, sleeping too much	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
e. Poor appetite or overeating	☐	☐	☐	☐
f. Feeling bad about yourself or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television.	☐	☐	☐	☐
h. 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.	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way.	☐	☐	☐	☐
2. If you checked off any problem on this questionnaire so far, 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
	☐	☐	☐	☐

Count the number (#) of boxes checked in a column. Multiply that number by the value indicated below, then add the subtotal to produce a total score. The possible range is 0-27. Use the table below to interpret the PHQ-9 score.

Not at all (#) _____ x 0 = _____
Several days (#) _____ x 1 = _____
More than half the days (#) _____ x 2 = _____
Nearly every day (#) _____ x 3 = _____

Total Score: _____

Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.	Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?					
3. How often do you have problems remembering appointments or obligations?					
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?					
					Part A
7. How often do you make careless mistakes when you have to work on a boring or difficult project?					
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
10. How often do you misplace or have difficulty finding things at home or at work?					
11. How often are you distracted by activity or noise around you?					
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?					
13. How often do you feel restless or fidgety?					
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?					
15. How often do you find yourself talking too much when you are in social situations?					
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?					
17. How often do you have difficulty waiting your turn in situations when turn taking is required?					
18. How often do you interrupt others when they are busy?					

Adverse Childhood Experience (ACE) Questionnaire
Finding your ACE Score

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often** …
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?
   ____Yes ____ No If yes enter 1 _____

2. Did a parent or other adult in the household **often** … Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   ____Yes ____ No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you **ever**…
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Try to or actually have oral, anal, or vaginal sex with you?
   ____Yes ____ No If yes enter 1 _____

4. Did you **often** feel that …
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each other?
   ____Yes ____ No If yes enter 1 _____

5. Did you **often** feel that …
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   ____Yes ____ No If yes enter 1 _____

6. Were your parents **ever** separated or divorced?
   ____Yes ____ No If yes enter 1 _____

7. Was your mother or stepmother:
Often pushed, grabbed, slapped, or had something thrown at her?
or
Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
or
Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
____Yes ____ No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
____Yes ____ No If yes enter 1 _____

9. Was a household member depressed or mentally ill or did a household member attempt suicide?
____Yes ____ No If yes enter 1 _____

10. Did a household member go to prison?
____Yes ____ No If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score