

Mental Health Flight, Wilford Hall Ambulatory Surgical Center, Lackland AFB, TX 78236

NEW PATIENT QUESTIONNAIRE

This form is subject to the Privacy Act of 1974

This questionnaire is designed to help your provider understand more about you. The primary purpose of asking these questions is to develop a treatment plan that will best suit the reasons that you came to this clinic. By answering these questions as completely and honestly as you can, we will be able to offer you the treatment most appropriate for your needs.

Today's Date: _____

Rank/Grade: _____ Branch: _____ Name: _____ Full SSN#/DoD ID: _____

DOB: _____ Age: _____ Marital Status: _____ Unit: _____ AFSC/Duty Title: _____

Commander's Name and Phone #: _____ First Sergeant's Name and Phone #: _____

Ethnicity: Latino/Hispanic American Indian/Alaskan White, not of Hispanic origin
 Asian/Pacific Islander Black, not of Hispanic origin Other

Physical Address: _____

Mailing Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

How would you prefer we contact you?: Home Phone Work Phone Cell Phone

Is it ok to leave a message? NO YES

Military Member's Time in Service: _____ Time at this base: _____ DEROS (if applicable): _____

Primary Care Clinic: Family Health Flight Med Other: _____ Name of PCM: _____

Military Status: Active Duty Guard Reserve Other: _____

Special Duty Status: TS/SCI PRP Weapons Flying/Controlling None

REFERRAL SOURCE:

_____ I decided to come to the Mental Health Clinic on my own, without the influence of anyone in my chain of command.

_____ I came to the Mental Health Clinic because my unit chain of command (*specify who*) _____ encouraged me to come, and I agreed to do so. I am here VOLUNTARILY.

_____ I came to the Mental Health Clinic because my unit chain of command (*specify who*) _____ encouraged me to come. I am NOT here VOLUNTARILY.

_____ I am here as the result of a Command Directed Evaluation. I was informed by my Commander/Supervisor that I must be at this appointment.

_____ I am here for a required military medical evaluation (e.g., MEB, TDRL, MTI/MTL/AMT, deployment clearance).

CHIEF COMPLAINT (PRIMARY CONCERN/PROBLEM):

Briefly describe the problems or concerns that brought you here today: _____

HISTORY OF PRESENTING ILLNESS/CURRENT SITUATION:

When did the problem/concern start? _____

Was there a specific incident/event that you think caused the problem/concern? NO YES, please explain: _____

How upsetting are the problems/concerns to you? Mild Moderate Severe

Is there something that makes the problem worse? NO YES, please explain: _____

Is there something that makes the problem better? NO YES, please explain: _____

What do you consider to be the top three stressors in your life?

1. _____

2. _____

3. _____

What do you hope to gain from your appointment today? _____

PSYCHIATRIC REVIEW OF SYSTEMS:

How would you describe your typical mood over the **last 2 weeks**?

Happy Sad Mad Depressed Numb Frustrated

Other: _____

Have you experienced any of the items below over the **last month**? (Check all that apply)

- | | | | | |
|---|--|--|---|--|
| <input type="checkbox"/> Poor Sleep | <input type="checkbox"/> Nightmares | <input type="checkbox"/> Sad/Depressed | <input type="checkbox"/> Low Motivation | <input type="checkbox"/> Decreased Interests |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Guilt | <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Low Energy | <input type="checkbox"/> Increased Energy |
| <input type="checkbox"/> Poor Concentration | <input type="checkbox"/> Poor Memory | <input type="checkbox"/> Distractibility | <input type="checkbox"/> Racing Thoughts | <input type="checkbox"/> Obsessive Thinking |
| <input type="checkbox"/> Appetite Change | <input type="checkbox"/> Weight Change | <input type="checkbox"/> Headache | <input type="checkbox"/> Vision Changes | <input type="checkbox"/> Impulsiveness |
| <input type="checkbox"/> Choking Sensation | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Rapid Heart Beat | <input type="checkbox"/> Panic Attack(s) | <input type="checkbox"/> Anxiety / Excessive Worry |
| <input type="checkbox"/> Nausea/Diarrhea | <input type="checkbox"/> Skin Problems | <input type="checkbox"/> Sexual Dysfunctions | <input type="checkbox"/> High/Low Sex Drive | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Sweating | <input type="checkbox"/> Muscle Tension | <input type="checkbox"/> Tics/Twitches | <input type="checkbox"/> Trembling/Shaking |
| <input type="checkbox"/> Blackouts | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Agitation | <input type="checkbox"/> Other: _____ | <input type="checkbox"/> None of these apply |

Do you have other habits or behaviors that you believe are excessive or out of control? NO YES, please explain: _____

PAIN:

Do you have any **physical** pain today? YES NO

If yes, circle the number that describes the amount of pain you are experiencing:

1 2 3 4 5 6 7 8 9 10

Slight

Moderate

Extreme

Where is your pain located? _____ Are you being seen by a health care provider for this pain? YES NO

CURRENT MEDICATIONS/OTC/HERBS/SUPPLEMENTS:

Please list **any** medications/supplements (including over the counter medications) you are currently taking or have taken within the **last year**

Medication/Supplement	Dosage	How often?	For what condition?

ALLERGIES:

Do you have allergies, including allergies to medications? NO YES, please list: _____

PAST MEDICAL, SOCIAL, FAMILY HISTORY:

MENTAL HEALTH HISTORY:

Please check any of the following that apply to you at any time in your life

- Had a Commander-Directed Evaluation
- Had a Family Advocacy evaluation or treatment
- Saw a school counselor for counseling
- Saw a psychiatrist
- Saw a psychologist or other counselor, on or off base
- Given a mental health diagnosis
- Saw a physician for a mental health problem
- Given medication for a mental health problem
- Attended inpatient residential treatment
- Had a psychiatric hospitalization
- Heard voices that no one else could hear
- Had visions or seen things that no one else could see
- Thoughts about harming yourself
- Thoughts about not wanting to live
- Thoughts about harming someone else
- Attempted suicide
- Engaged in selfharming behaviors, such as burning or cutting yourself without intent to die
- None of these apply

If endorsed, please explain: _____

FAMILY MENTAL HEALTH HISTORY:

Has anyone in your family had mental or emotional problems? NO YES, please explain: _____

Have you had family members who attempted or committed suicide? NO YES, please explain: _____

Have anyone in your family had substance abuse or dependence related problems? NO YES, please explain: _____

MEDICAL/SURGICAL HISTORY:

Have you ever had or do you now have a serious illness, surgery, broken bones, or other significant medical problem? NO YES, please explain: _____

Have you ever had a concussion? NO YES

Did you lose consciousness? NO YES

Have you ever had a seizure? NO YES

Have you ever had a combat related injury? NO YES, please explain: _____

Have you ever had surgery? NO YES, please explain: _____

Do you have any physical limitations or barriers that we should be aware of? NO YES, please explain: _____

(Females Only) Are you, or is there a chance you might be, pregnant? NO YES

Has anyone in your family ever had a serious medical problem (e.g., cancer, diabetes, heart disease, etc.) ? NO YES, please explain: _____

OCCUPATIONAL/MILITARY HISTORY:

Date of Enlistment/Commissioning: _____ Total time in the military? _____ Time at current base? _____

Typical duties: _____

Number of Duty Assignments: _____ Last Duty Station: _____

Will you PCS in the next year? NO YES, Location: _____ When: _____

Are you planning to separate from the service? NO YES, when: _____

Do you have an extended TDY (greater than 1 week) expected in the next six months? NO YES, Where? _____

Deploying within the next six months? NO YES, When? _____ Where? _____

Have you ever deployed? NO YES, Location / When: _____

If you have deployed, did you experience any distressing events? NO YES, please explain: _____

Are you experiencing any problems with your work performance? NO YES, please explain: _____

Are you experiencing any problems with your supervisor / chain of command? NO YES, please explain: _____

Do you feel physically and emotionally safe at work? NO YES, please explain: _____

Have you ever had a disciplinary action (LOC, LOR, UIF, Article 15)? NO YES, please explain: _____

How satisfied are you with your current occupation?

Very Unsatisfied Unsatisfied Satisfied Very Satisfied

Have you experienced any work related difficulties in the past? NO YES, please explain: _____

Over the last year have you had any PT (*physical training test*) failures or difficulties? NO YES

CIVILIAN EMPLOYMENT HISTORY: (if applicable)

Are you currently employed? NO YES, where? _____

Are you having any job related difficulties? NO YES, please explain: _____

LEGAL/FINANCIAL:

Are you experiencing legal difficulties? NO YES, please explain: _____

Are you experiencing financial difficulties? NO YES, please explain: _____

SOCIAL/DEVELOPMENTAL HISTORY:

CHILDHOOD:

Where did you grow up? _____

Who raised you? Biological Parents Biological Mother and Step-Father Biological Father and Step-Mother

Adoptive parents Single Parent- Mother Single Parent Father

Paternal Grandparent(s) Maternal Grandparent(s) Foster Parent(s)

Other: Please list _____

Number of Brothers: _____ Number of Sisters: _____

Who was the most significant person in your childhood? _____

What was your childhood like? _____

Did you feel neglected by your caregivers? NO YES

Did you ever experience or witness any verbal, emotional, physical, or sexual abuse? NO YES

If yes, are memories of that abuse bothering you now? NO YES

Do you feel that childhood events contribute to your current concerns? NO YES

CURRENT LIVING/RELATIONSHIP STATUS:

Select the choice that best describes your living situation:

Single/Living in the dorms Single/Living off base Married/Living with spouse on base

Married/Living with spouse off base Married/Living separately from spouse Living with parents/family

Other: _____

Number of Marriages: _____ Number of Years Currently Married: _____

Do you have children? NO YES, gender / ages: _____

Are you currently experiencing:

Problems living in the dorms Problems with neighbors Problems living with spouse

Issues related to living separately from spouse Issues related to children/parenting

Issues related to your parents/extended family Issues related to deployment Physical Abuse

Verbal Abuse Sexual Abuse Other: _____

Do you have access to any guns or other weapons? NO YES

Do you feel physically safe at home? YES NO, please explain: _____

Do you feel emotionally safe at home? YES NO, please explain: _____

SPIRITUAL/RELIGIOUS/CULTURAL BELIEFS/CONCERNS:

Do you have a religious affiliation or spiritual practice? NO YES, please explain: _____

Are you currently participating in religious or spiritual activities? NO YES

How important are your religious / spiritual beliefs in everyday life?

Not at all To a small extent To a moderate extent To a large extent To a very large extent

Do you have any religious/ spiritual concerns? NO YES Would you like to speak to a Chaplain? NO YES

BARRIERS TO LEARNING/READINESS TO LEARN:

Is English your primary language? YES NO, please identify your primary language _____

Do you have any speech, language, or verbal communication problems? NO YES, please explain: _____

What is your preferred learning style?

Visual Oral Written Combination

What is the highest education you have completed?

GED HS diploma Some College Bachelor's Some Graduate Graduate Degree

Are you currently in school? NO YES, provide details: _____

Are you experiencing any academic-related difficulties? NO YES, please explain: _____

SUBSTANCE USE:

Do you use alcohol? NO YES, how often do you have a drink containing alcohol? _____

How many drinks on average do you have, per sitting? _____

Have you ever tried to cut down on your drinking? NO YES

Have you ever been seen in ADAPT or a substance abuse program? NO YES, when / where? _____

Do you smoke or use smokeless tobacco? NO YES, how much? _____ Would you like to quit? NO YES

Do you consume caffeinated drinks? NO YES, what beverages? _____
how often per day? _____ how often per week? _____

Do you use supplements? NO YES, what supplements do you use? _____ how often do you use them? _____

Have you ever used an illegal substance? NO YES, what substance and when did you use it? _____

GOALS FOR TREATMENT:

What three things would you like to see improved through treatment??

- 1. _____
- 2. _____
- 3. _____

What percentage (0-100%) of confidence do you have that you can help yourself make the changes that you identified above without any assistance from therapy?

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
Not Total
Confident Confidence

What percentage (0-100%) of confidence do you have that you can help yourself make the changes that you identified above with assistance from therapy?

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
Not Total
Confident Confidence

How motivated are you to learn new ways to deal with your problems?

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
Not Completely
Motivated Motivated

Patient's Signature: _____

Date: _____

Provider Stamp and Signature: _____

Date: _____