PATIENT QUESTIONNAIRE

Welcome! Please take a few minutes to fill this out. The information will help us better understand your situation and needs.
If there are questions you are uncomfortable answering, wait and discuss them with a staff member.

Today's Date	**Name: (First)**	**(Middle)**	**(Last)**	**(Last Name at Birth)**

Social Security Number	**Age**	**Date of Birth**	**Home Phone**	**Other Phone**

Address: (No. & Street)	**(Apt No.)**	**(City)**	**(State & Zip Code)**	**(County)**

Person Completing this Form: **Relationship to You:**

Gender: (check one)	**Sexual Orientation:** (check one)	**Current Marital Status:** (check one)
☐ Male ☐ Female	☐ Bisexual ☐ Other	☐ Single ☐ Divorced/Annulled
☐ Transgender-Male to Female	☐ Chose not to disclose ☐ Unknown	☐ Separated ☐ Widowed
☐ Transgender-Female to Male	☐ Straight or heterosexual	☐ Domestic Partner
	☐ Lesbian, gay or homosexual	☐ Married - How Long? _____

Education: High School Graduate: ☐ Yes ☐ No Last Grade Completed: _____ GED: ☐ Yes ☐ No Voc Ed: ☐ Yes ☐ No

Years of College completed: _____ College Degree: ☐ Yes ☐ No Degree Type: _____

Race: ☐ Alaskan ☐ American Indian ☐ Asian ☐ Black or African American ☐ Native Hawaiian/ Other Pacific Islander ☐ Native American ☐ White/Caucasian ☐ Other _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Have you ever been in the military? ☐ Yes ☐ No – **If Yes, what are your dates of service and branch?** _____

Do you have a legal guardian? ☐ Yes ☐ No – **If Yes, guardian name & phone no.?** _____

Are you currently seeing a therapist, counselor, psychologist, or social worker? ☐ Yes ☐ No

Are you currently attending an addiction treatment program? ☐ Yes ☐ No – If Yes, where? _____

Are you currently involved with the Child Welfare system/foster care? ☐ Yes ☐ No

Are you currently on parole/probation? ☐ Yes ☐ No – **If Yes, please complete the following information:**

_____ _____ _____

PO/ISO **Address** **Phone**

Who referred you to COMCARE?

COMCARE
A Licensed Community Mental Health Center

Sedgwick County... working for you

Insurance / Coverage Provider: **Medicaid/Medikan/Medicare/Private:** _____	
Employment: ☐ Full-time ☐ Part-time # of hours weekly _____	**Employer:** (If none, write none)
EMERGENCY CONTACT: Name:_____ Relationship to you: _____ Address:_____ Home Phone:_____ Work Phone: _____	

Please list the reasons that bring you here today. This may include concerns, problems, significant losses or changes that are causing you to seek treatment at this time.

_____

_____

_____

Over the last **2 weeks**, how often have you been bothered by any of the following problems? (Please check your answer)

	PHQ – 9 Questionnaire	Not at all	Several days	More than half the days	Nearly Every day
1.	Little interest or pleasure in doing things	☐0	☐1	☐2	☐3
2.	Feeling down, depressed, or hopeless	☐0	☐1	☐2	☐3
3.	Trouble falling or staying asleep, or sleeping too much	☐0	☐1	☐2	☐3
4.	Feeling tired or having little energy	☐0	☐1	☐2	☐3
5.	Poor appetite or overeating	☐0	☐1	☐2	☐3
6.	Feeling bad about yourself – or that you are a failure or have let yourself or your family down	☐0	☐1	☐2	☐3
7.	Trouble concentrating on things, such as reading the newspaper or watching television	☐0	☐1	☐2	☐3
8.	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	☐0	☐1	☐2	☐3
9.	Thoughts that you would be better off dead or of hurting yourself in some way?	☐0	☐1	☐2	☐3

GAD – 7 Questionnaire	Not at all	Several days	More than half the days	Nearly Every day
1. Feeling nervous, anxious or on edge	☐0	☐1	☐2	☐3
2. Not being able to stop or control worrying	☐0	☐1	☐2	☐3
3. Worrying too much about different things	☐0	☐1	☐2	☐3
4. Trouble relaxing	☐0	☐1	☐2	☐3
5. Being so restless that it is hard to sit still	☐0	☐1	☐2	☐3
6. Becoming easily annoyed or irritable	☐0	☐1	☐2	☐3
7. Feeling afraid as if something awful might happen	☐0	☐1	☐2	☐3

If you checked off any problems, 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
☐	☐	☐	☐

Source: PHQ-9 and GAD-7 developed by Drs Robert L Spitzer, Janet BW Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer, Inc.

Additional Screening Questions	YES	NO	UNSURE
1. I see or hear things that others do not see or hear.	☐	☐	☐
2. I believe that someone may be watching me, planning to harm me, or may be about to harm me in the near future.	☐	☐	☐

AUDIT-C Questionnaire

1. How often do you have a drink containing alcohol?
   - ☐ A. Never
   - ☐ B. Monthly or less
   - ☐ C. 2-3 times a month
   - ☐ D. 2-3 times a week
   - ☐ E. 4 or more times a week

2. How many standard drinks containing alcohol do you have on a typical day?
   - ☐ A. 1 or 2
   - ☐ B. 3 or 4
   - ☐ C. 5 or 6
   - ☐ D. 7 to 9
   - ☐ E. 10 or more

3. How often do you have six or more drinks on one occasion?
   - ☐ A. Never
   - ☐ B. Less than monthly
   - ☐ C. Monthly
   - ☐ D. Weekly
   - ☐ E. Daily or almost daily

CAGE-AID Questionnaire

When thinking about drug use, include illegal drug use and the use of prescription drug use other than prescribed.

		YES	NO
1.	Have you ever felt that you ought to cut down on your drinking or drug use?	☐	☐
2.	Have people annoyed you by criticizing your drinking or drug use?	☐	☐
3.	Have you ever felt bad or guilty about your drinking or drug use?	☐	☐
4.	Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?	☐	☐

Source: Brown RL, Leonard T, Saunders LA, Papasouliotis O. The prevalence and detection of substance use disorder among inpatients ages 18 to 49: an opportunity for prevention. Preventive Medicine. 1998;27:101-110.

Brief Bio-social Gambling Screen (BBGS)

	During the <u>past 12 months</u>:	YES	NO
1.	Have you become restless, irritable or anxious when trying to stop/cut down on gambling?	☐	☐
2.	Have you tried to keep your family or friends from knowing how much you gambled?	☐	☐
3.	Did you have such financial trouble that you had to get help from family or friends?	☐	☐

Source: Gebauer, L., LaBrie, R. A., & Shaffer, H. J. (2010). Optimizing DSM-IV classification accuracy: A brief bio-social screen for gambling disorders among the general household population. Canadian Journal of Psychiatry, 55(2), 82-90.

Medical History:

Primary Care Physician:_____Address of Physician:_____

City of Physician_____State of Physician_____Zip _____

Please check all that apply:

Smoke tobacco (Vaping, Chewing, Smoking)	Heart problems
Asthma	High Blood Pressure
COPD	☐ Head injury/Loss of consciousness
Active Tuberculosis	☐ Blackouts
Diabetes	☐ Tremors
☐ Epilepsy/Seizures	Weight loss
☐ Hepatitis: ☐A ☐B ☐C (check all that apply)	Weight gain
☐ HIV /AIDS	Other Chronic illness: _____
☐ Arthritis	Serious injury: What? _____

Current health concerns:

_____

For women:

Are you currently pregnant? ☐ No ☐ Yes (# of weeks pregnant:_____due date:_____)

Number of pregnancies:_____ Number of births:_____

Current Prescribed Medications	Dose	How Often	Prescribed by

Are you allergic to any medications or drugs? ☐ No ☐ Yes (describe) _____

Spiritual and Religious History: Are there any religious or spiritual influences or practices that are important to you? Please list below:

_____

Current Legal Status: Are you currently involved in any active cases (traffic, civil, criminal)? ☐ No ☐ Yes

Past Legal History: (Check all that apply)

Traffic Violations ☐ No ☐ Yes Other ☐ No ☐ Yes Incarcerated? ☐ No ☐ Yes

Leisure / Recreational Activities: Describe special areas of interest or hobbies (e.g. art, books, crafts, exercise, sports, outdoor activities, church activities, fishing, traveling, TV shows, etc.):

_____

COMCARE
A Licensed Community Mental Health Center

Sedgwick County... working for you

Clear Form