WILLAMETTE VALLEY PSYCHIATRIC MEDICINE, LLC

PSYCHIATRY

132 E Broadway, Suite 201, Eugene, OR 97401
T (541) 344-5363 **F** (541) 344-5369
www.wvpsych.com

NEW PATIENT QUESTIONNAIRE

Please complete and bring to your appointment.

Appointment: **Provider:**

_____

Elaine Mitchell, DO
Tim Mitchell, MD
Karen Crocker-Wensel, MD

Please note that we will not be able to reschedule your appointment if you cancel or attempt to reschedule with less than two business days' notice.

Patient name & age: **Referral by**:

_____ _____

Chief concern(s).
In a few words, explain the difficulty you are having that brings you to this appointment and how long it's been ongoing:

_____
_____

Other possible areas of concern.
*Are you **currently** having problems or changes with any of the following? If so please **describe in a few words**. We'll have a chance to elaborate when we meet.*

Moods (up/down): _____
Anxiety/Worry: _____
Crying spells: _____
Sleep: _____
Appetite: _____
Weight: _____
Energy: _____
Memory/concentration: _____
Blackouts: _____
Self Esteem: _____
Hopelessness: _____
Suicidal thoughts: _____
Thoughts of hurting yourself: _____
Thoughts of hurting another: _____
Motivation: _____
Pleasure: _____
Relationships: _____
Sex drive: _____
Obsessions/Compulsions:_____
Other: _____

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Stressors.
*What are the most stressful events you have experienced in **the past year**?*

_____
_____
_____

Current treatment.
A*re you **presently** seeing a doctor or counselor/therapist?* *Yes* *No*
If so, with ***whom***:

_____
_____

*Are you **presently** taking psychiatric medications?* *Yes* *No*
If so, please list names and doses and how long you've been on each:

_____
_____
_____
_____

Past Psychiatric Care.
Have you ever had emotional or mental difficulties before? *Yes* *No*
If so, please describe ***when*** and ***what*** condition:

_____
_____
_____

Have you ever seen a psychiatrist? *Yes* *No*
If so, please describe ***when, where***, for ***what*** condition, and with ***whom***:

_____
_____
_____

Have you ever used psychiatric medicines? *Yes* *No*
As best you remember, please list any ***prior*** psychiatric medicines you have tried:

_____
_____
_____
_____

Have you ever been psychiatrically hospitalized? *Yes* *No*
If so, please describe ***where***, ***when***, and for ***what*** condition:

_____
_____

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Have you ever had psychotherapy/counseling? *Yes* *No*
If so, please describe ***when, where***, for ***what*** condition, and with ***whom***:

_____
_____
_____

Have you ever attempted suicide? *Yes* *No*
If so, when:_____
Have you ever engaged in other self abusive behavior? *Yes* *No*
If so, when:_____
Have you ever physically assaulted another? *Yes* *No*
If so, when:_____

Medical History.
*Who is your current **primary care** provider?*

_____

*What other **specialists** do you see?*

_____

*List current medical/**physical health conditions**:*

_____
_____

*Describe any current **physical symptoms** that concern you?*

_____
_____

Current: ***height***: _____ ***weight:*** _____ *Preferred* ***weight***:_____

Have you ever had:

Surgeries? *Yes* *No*
Describe briefly:_____
A seizure? *Yes* *No*
Describe briefly:_____
A head injury? *Yes* *No*
Describe briefly:_____
Other physical trauma? *Yes* *No*
Describe briefly:_____
Other hospitalizations? *Yes* *No*
Describe briefly: _____

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*List your other **current medications** and doses (to include vitamins, nutritional supplements, and other over the counter medicines):*

*List any **allergies**:* *Preferred **pharmacy** and location:*

Social History.
*Where were you **born** and **raised?***

*Briefly describe the nature/quality of your **family relations** while growing up:*

*Briefly describe the nature/quality of your **friendships** while growing up:*

*Have you ever experienced any significant **traumas**?* *Yes* *No*

Current Social Situation.
*How many years and what type of **education** have you had?*

*What is your current **job**?*

*What is your current **living situation**/arrangement?*

*Are you, **Single**? **Married**? **Partnered**?*

*How many **children** do you have? Please list their names and ages.*

*How are your current **family relations**?*

*How are your current **friendships**?*

*What type of **exercise** do you do and how often?*

*What do you do for **fun**?*

*How would you describe your **personality** style?*

*What is your **spiritual** orientation?*

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*Do you have any current/past **legal** problems?* *Yes* *No*
Please describe: _____

Family History.
*Please indicate if anyone in your **family** had any of the following conditions/problems by briefly describing:*
Depression: _____
Manic-Depression (Bipolar):_____
Schizophrenia: _____
Anxiety Conditions: _____
Alcoholism: _____
Drug Addiction: _____
Anger Problems: _____
ADHD/ADD: _____
Diabetes: _____
Heart Disease: _____

Substance Use.
Please describe what, how much, and how often you have used:

Alcohol:

_____

_____

Drugs:

_____

_____

*T**obacco**:*

_____

Caffeine:

_____

*Describe any **problems/treatment** you may have had related to use of:*
Alcohol: _____
_____
_____
Drugs: _____
_____
_____

Thank you for your effort!
