Part I. Demographics

Today's Date	Current Time
	:

Patient's Name (Last) (First) (MI)	**Patient's Date of Birth**	**Patient's Gender** ☐ Female ☐ Male
Patient's Address		
Primary Phone	**Ok to leave a message?** ☐ Yes ☐ No	**Email Address**
Patient's Race/Ethnicity ☐ African American/Black ☐ Asian American ☐ Caucasian/White ☐ Hispanic/Latino ☐ Native American ☐ Other: _____		
Years of Education of Patient ☐ < 12 ☐ 12 (or GED) ☐ 13 ☐ 14 ☐ 15 ☐ 16 ☐ 17 ☐ 18 ☐ >18		**Were you ever in the military?** ☐ No ☐ Yes (Branch?):
Relationship Status of Patient ☐ Single, Never Married ☐ Married ☐ Partnered ☐ Divorced ☐ Separated ☐ Widowed		
Employment Status ☐ Working Full Time ☐ Working Part Time ☐ Retired ☐ Unemployed		**Disability Status** ☐ N/A ☐ Short-Term ☐ Permanent
Is the person completing this form the patient or someone else? ☐ Patient ☐ Family Member ☐ Friend		**# of people living in your home with you:**
In case of emergency, please contact: Name:	**Relationship to Patient:**	**Phone # of Emergency Contact:**

Part II. Presenting Problem

Who referred you to WellStar Psychological Services?

Briefly describe the problem you having that brings you here:

How long have you been dealing with this problem?

What are your expectations regarding today's visit?

Part III. Recent Medical Treatment

Do you have any known medical problems right now? ☐ Y ☐ N	
☐ If N/A, check and proceed to question below.	If yes, list all here:

Are you in any physical pain right now? ☐ Y ☐ N	
☐ If N/A, check and proceed to section below.	If yes, where is your pain located:
	If yes, how long have you had this pain?
	On a scale of 0 to 10 (0 being none and 10 being excruciating), rate your pain right now:

Please list the name of any medical providers you have seen **within the past year** and the reason for your visit. If you have not seen one of the provider types listed, check the box marked N/A, for Not Applicable.

N/A	Type	Provider Name(s)	Reason(s)
☐	Primary Care		
☐	Counselor		
☐	Psychiatrist		
☐	Cardiologist		
☐	Pulmonologist		
☐	Neurologist		
☐	Oncologist		
☐	Surgeon		
☐	Other -		

Please list the names and dosages of any medications you are **currently** taking. If you have brought a list of these medications with you today, check the box next to "See Attached List" and proceed to the next section

☐ See Attached List

Name of Medication	Dosage	Frequency	Prescribing Physician	Currently Taking?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

Part IV. Emotional & Behavioral History

Have you **ever** received treatment for mental health (including counseling/therapy or substance abuse) problems? ☐ Y ☐ N	
☐ If N/A, check and proceed .	If yes, when?
	Reason you sought treatment:
	Were you ever hospitalized? ☐ Y ☐ N
	Any mental health diagnosis? ☐ Y ☐ N If so, please list:

Complete the table below with respect to any problems you have ever been experienced in the past:

Problem	Never diagnosed or treated for this problem	Approximate year I was first diagnosed	Approximate year I first received treatment	Currently receiving treatment?
Attention deficit hyperactivity disorder	☐			☐ Y ☐ N
Anxiety disorder	☐			☐ Y ☐ N
Autism or Aspergers disorder	☐			☐ Y ☐ N
Bipolar disorder	☐			☐ Y ☐ N
Depression	☐			☐ Y ☐ N
Eating disorder	☐			☐ Y ☐ N
Learning disability	☐			☐ Y ☐ N
Posttraumatic stress disorder	☐			☐ Y ☐ N
Schizophrenia	☐			☐ Y ☐ N
Tourette's	☐			☐ Y ☐ N
Other:	☐			☐ Y ☐ N

Complete the table below with respect to any substances you currently use **and/or** have used in the past.

Substance	Check if never used	Average Amount (#, $, oz, etc.) you have used each week during the last month	Age Substance Became a Problem	Approximate date of last use	Currently Using?
Alcohol	☐		☐ N/A		☐ Y ☐ N
Amphetamines	☐		☐ N/A		☐ Y ☐ N
Methamphetamine	☐		☐ N/A		☐ Y ☐ N
Cocaine/Crack	☐		☐ N/A		☐ Y ☐ N
Other Stimulants	☐		☐ N/A		☐ Y ☐ N
Heroin	☐		☐ N/A		☐ Y ☐ N
Hallucinogens	☐		☐ N/A		☐ Y ☐ N
Opiates	☐		☐ N/A		☐ Y ☐ N
Marijuana	☐		☐ N/A		☐ Y ☐ N
Nicotine	☐	= amt. per day	☐ N/A		☐ Y ☐ N
Other:	☐		☐ N/A		☐ Y ☐ N

Neuropsychological Assessment

Handedness

☐ Right-hand dominant ☐ Left-hand dominant ☐ Ambidextrous

Did you have any significant health problems as a child that impacted your ability to think or learn? ☐ No ☐ Yes If yes, please describe:	Before age 12, did you have any problems with attention or learning that caused you difficulty in school? ☐ No ☐ Yes If yes, please describe:	Do you have any family members with neurological disease (e.g. Alzheimer's, Parkinson's, other dementias? ☐ No ☐ Yes If yes, please describe:
Have you been prescribed glasses? ☐ No ☐ Yes If applicable, do you use them? ☐ N/A ☐ No ☐ Yes	Have you been prescribed hearing aids? ☐ No ☐ Yes If applicable, do you use them? ☐ N/A ☐ No ☐ Yes	Have you been prescribed a CPAP? ☐ No ☐ Yes If applicable, do you use it? ☐ N/A ☐ No ☐ Yes
Have you **ever** been prescribed stimulant medications? ☐ No ☐ Yes If applicable, when did you last take this medication? ☐ N/A ☐ Mo/Year: _____	Have you **ever** been prescribed medications for pain, sleep, or anxiety? ☐ No ☐ Yes If applicable, when did you last take this medication? ☐ N/A ☐ Mo/Year: _____	Have you **ever** undergone chemotherapy or radiation treatment? ☐ No ☐ Yes If applicable, when did you last receive this treatment? ☐ N/A ☐ M/Year: _____

Have you **ever** had a head or neck injury that caused you to lose consciousness or to feel dazed or confused? ☐ Y ☐ N

If yes to the above question, please list each event you remember starting with the most recent:

#	Year	Reason for injury (e.g. fall, car accident, etc.)	Did you lose consciousness?	Did you receive medical treatment?
1			☐ Y ☐ N	☐ Y ☐ N
2			☐ Y ☐ N	☐ Y ☐ N
3			☐ Y ☐ N	☐ Y ☐ N
4			☐ Y ☐ N	☐ Y ☐ N
5			☐ Y ☐ N	☐ Y ☐ N
6			☐ Y ☐ N	☐ Y ☐ N
7			☐ Y ☐ N	☐ Y ☐ N

Complete the table below regarding your sleep habits **over the past week**.

Time I usually went to bed at night *(approximate if necessary)*		**Time I usually fell asleep at night** *(approximate if necessary)*		**Time I usually woke up the morning** *(approximate if necessary)*		**Time I usually got out of bed to start the day** *(approximate if necessary)*	
Weekdays	:	**Weekdays**	:	**Weekdays**	:	**Weekdays**	:
Weekends	:	**Weekends**	:	**Weekends**	:	**Weekends**	:
Average # of times I woke up each night		**Average # minutes it took me to go back to sleep after waking** *(in minutes)*		**# of days I took a nap in the last month**		**Average # minutes per nap I took in the last month** *(in minutes)*	

Complete the table below with respect to any problems you have experienced in the past 12 months.

Symptom	Yes/No	Approx. Date of Onset	Description
Difficulty finding my words	☐ Y ☐ N		
Difficulty remembering names of familiar people	☐ Y ☐ N		
Forgetting conversations I recently had	☐ Y ☐ N		
Forgetting appointments, obligations, etc.	☐ Y ☐ N		
Inability to remember recent events	☐ Y ☐ N		
Difficulty remembering things from the past	☐ Y ☐ N		
Difficulty remembering how to do things I used to d	☐ Y ☐ N		
Difficulty recognizing faces of people I know	☐ Y ☐ N		
Difficulty developing a plan	☐ Y ☐ N		
Difficulty following through with tasks	☐ Y ☐ N		
Trouble multi-tasking	☐ Y ☐ N		
Unable to focus	☐ Y ☐ N		
Getting easily distracted when I'm trying to concen	☐ Y ☐ N		
Trouble following conversations	☐ Y ☐ N		
Getting lost in familiar places	☐ Y ☐ N		
Difficulty pronouncing words	☐ Y ☐ N		
Speech slurred for no understandable reason	☐ Y ☐ N		
Acting without thinking of consequences	☐ Y ☐ N		
Making bad decisions more than usual	☐ Y ☐ N		
Loss of motivation and interest doing things	☐ Y ☐ N		
Feeling unable to stop doing something	☐ Y ☐ N		
Unable to see consequences of actions until later	☐ Y ☐ N		
Headaches	☐ Y ☐ N		
Dizziness	☐ Y ☐ N		
Clumsiness	☐ Y ☐ N		
Stumbling when walking	☐ Y ☐ N		

Numbness/tingling in my arms or legs	☐ Y ☐ N		
Problem swallowing	☐ Y ☐ N		
Ears ringing	☐ Y ☐ N		
Feeling nauseated	☐ Y ☐ N		
Vomiting	☐ Y ☐ N		
Change in vision	☐ Y ☐ N		
Seizures	☐ Y ☐ N		

Rate yourself according to how you feel your skills and/or knowledge compare to other individuals your age.

	Poor		Average		Superior
1. Vocabulary	1	2	3	4	5
2. Reading Comprehension	1	2	3	4	5
3. Spelling	1	2	3	4	5
4. Grammar (i.e. using words correctly when speaking/writing)	1	2	3	4	5
5. Creative Writing (e.g. writing a short story)	1	2	3	4	5
6. Basic Writing (e.g. writing a letter)	1	2	3	4	5
7. Mental Computation (e.g. adding numbers in your head)	1	2	3	4	5
8. Higher-Level Mathematics (e.g. algebra/trigonometry)	1	2	3	4	5
9. Knowledge of Geography	1	2	3	4	5
10. Knowledge of History	1	2	3	4	5
11. Knowledge of Sciences (e.g. chemistry/biology)	1	2	3	4	5
12. Knowledge of Social Sciences (e.g. psychology/sociology)	1	2	3	4	5
13. Art (e.g. drawing/painting/sculpture)	1	2	3	4	5
14. Music (e.g. singing on key)	1	2	3	4	5
15. Working with your hands (e.g. using tools to fix things)	1	2	3	4	5
16. Athleticism	1	2	3	4	5
17. Problem-Solving	1	2	3	4	5
18. Creativity	1	2	3	4	5
19. Memorizing facts	1	2	3	4	5
20. Organizational ability (i.e. making a plan and following it)	1	2	3	4	5

Patient's Name (Last)	(First)	(MI)	**Today's Date**

The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the past **TWO (2) WEEKS.**

			None	**Slight**	**Mild**	**Moderate**	**Severe**	
During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems? Please circle 0,1,2,3, or 4			Not at all	Rarely, less than a day or 2	Several days	More than half the days	Nearly every day	**CLINICIAN ONLY**
I	1	Little interest or pleasure in doing things?	0	1	2	3	4	
	2	Feeling down, depressed, or hopeless?	0	1	2	3	4	
II	3	Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III	4	Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5	Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV	6	Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7	Feeling panic or being frightened?	0	1	2	3	4	
	8	Avoiding situations that make you anxious?	0	1	2	3	4	
V	9	Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10	Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI	11	Thoughts of actually hurting yourself?	0	1	2	3	4	
VII	12	Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13	Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII	14	Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX	15	Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X	16	Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	

	17	Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI	18	Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII	19	Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20	Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII	21	Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22	Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23	Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	

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Please circle Yes or No in response to the following questions.				**CLINICIAN ONLY**
1	In the past month, have you wished you were dead or wished you could go to sleep and not wake up?	Yes	No	
2	In the past month, have you actually had any thoughts about killing yourself?	Yes	No	

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