

**NEW PATIENT QUESTIONNAIRE**

*This form is subject to the Privacy Act of 1974*

This questionnaire is designed to help your provider better understand you and will be used as an aid in developing a treatment plan that suits your needs. This form will be included in your Mental Health record. It will not be included in your medical record. Please complete ALL information in this packet.

Today's Date: \_\_\_\_\_  
 (Please circle the correct response)

I am presenting to this session voluntarily: YES / NO (If no, please inform your provider)

**I. DEMOGRAPHICS**

Name & Rank:		Age: Date of Birth: Gender:	Special Duty Status (please circle one) TS/SCI    PRP    FLYING WEAPONS    Not Applicable		
Command Information: Unit: 1 <sup>st</sup> Sgt's Name:		Home Phone: Work Phone: Pager / Cell Phone:	Local Address:		
Marital Status: Time in current relationship: Number of previous spouses		Branch of Service:	Status (please circle one):    AD/ Dep/ Civilian/ Ret/ Res/ ANG Military Member's Time in Service: Time at Base:		
Is English your primary language? Yes / No If not, what is your primary language _____		Do you need a language interpreter? Yes / No	Do you have difficulty reading or writing? Yes / No If yes, please explain:		
		Ethnicity/ Cultural Background (optional):			
Spouse's Name (If applicable): Please list your children's names, ages, genders, and locations (If applicable):					
Primary Care Facility:		Primary Care Manager's Name (if known):			

Do not write in this Section	FOR STAFF USE ONLY!			Y	N	N/A
Have you gone over Patient Information Sheet (limits of confidentiality, rights/responsibilities, record keeping, provider options, and feedback about services)?						
Is pt on PRP? Flyer?						
Does pt have security clearance higher than secret?						
Does pt carry a weapon on his/her job on a regular basis?						
Is pt currently on a medical profile for a mental health condition?						
Does pt history indicate a concern about harm to others or self?						
Is Privacy Act Statement signed (DD Form 2005)?						
Ask verbatim: Are you here voluntarily or at the direction of your commander or supervisor? _____						
(IAW AFI 44-109, 4.3.2, if member says the latter and the commander has not initiated a CDE, provider must contact commander to determine if a CDE is intended. If not, the provider shall inform pt that the evaluation is not required, but may proceed on a voluntary basis if the pt chooses.) Document any interaction with the pt's commander here.						

Rank/Name: \_\_\_\_\_ FMP/SSN: \_\_\_\_\_

**II. PRIMARY CONCERN**

1. Is your visit today related to a deployment?      Yes / No      Date(s) of deployment: \_\_\_\_\_

2. Briefly list or describe the problems or concerns that brought you to the clinic today:  
 \_\_\_\_\_  
 \_\_\_\_\_

3. What led to your decision to seek help now?  
 \_\_\_\_\_  
 \_\_\_\_\_

4. How upsetting to you is the problem or concern that brought you in today? (circle one)  
 Mild      (Minimal difficulty completing tasks, minimal impact on daily functioning, not very noticeable to others, etc)  
 Moderate      (Notable difficulty completing tasks or interacting with others, somewhat noticeable to others, etc)  
 Severe      (Major impact on ability to function and complete tasks throughout the day, very noticeable to others, etc)

5. What makes the problem worse? \_\_\_\_\_

6. What makes the problem better? \_\_\_\_\_

7. **Please check** the extent to which each item below has been a problem for you over the **past month**.

	No Problem	Mild Problem	Moderate Problem	Extreme Problem
<b>S:</b> Sleeping too much				
Difficulties falling asleep				
Difficulties staying asleep				
Waking earlier than desired				
<b>I:</b> Loss of interest in pleasurable activities				
Sad more days than not				
<b>G:</b> Excessive guilt				
Feeling worthless				
<b>E:</b> Decreased energy				
Increased energy				
<b>C:</b> Difficulties with concentration/memory				
<b>A:</b> Increased appetite				
Decreased appetite				
<b>P:</b> Unable to sit still				
Moving so slowly others notice				
<b>S:</b> Changes in sexual interest				
Mood Swings				
Feeling sad or depressed				
Feeling nothing or feeling numb				
Anger				
Temper outbursts				
Regretting some behaviors ( e.g., spending too much				
Irritability				
Anxiety or fear				
Worry about social or performance situations				

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	No Problem	Mild Problem	Moderate Problem	Extreme Problem
Avoiding places, people, or situations				
Inability to stop worrying				
Seeing things that others may not see				
Hearing things that others may not hear				

8. Please check all that apply.

	Never	Previously (+6 months ago)	Recently (in last 6 months)	Currently (in last week)
Recurrent thoughts about death				
Recurrent thoughts about killing yourself				
Recurrent thoughts about killing others				
Engaging in self-harming behaviors, such as cutting or burning, without intent to die				
Active preparation to kill yourself (e.g., writing goodbye letter, purchasing pills, obtaining a weapon)				
Thinking out a plan to kill yourself				
Thinking out a plan to kill others				
Active preparation to kill others				
Attempting to kill yourself				
Attempting to kill others				
Believing that others would be "better off" if you die				
Feeling hopeless about your life and future				
A family member or close friend completing suicide				
Voices telling you to hurt or kill yourself or others				
Being more physically or verbally aggressive than you intended with your spouse or children				
A physical altercation in which you caused injury				
Throwing or breaking things when angry				
Arrest for physical violence				

**III. MEDICAL**

Check the physical symptoms you have been having over the past month.

Dry mouth	Nausea	Fatigue	Chest pain
Sweating	Urinary problems	Excessive snoring	Constant pain
Rapid heart beat	Diarrhea	Taking medication to sleep	Back pain
Shortness of breath	Constipation	Restless legs	Muscle tension
Chills/Hot flashes	Stomach problems	Nightmares	Sexual Dysfunction
Trembling/Shaking	Choking sensation	Changes in hearing or vision	Blackouts
Tics/Twitches	Unexplained weight loss	Fainting or dizzy spells	
Numbness in extremities	Unexplained weight gain	Headaches	

**Current and past medical conditions** (Circle your response to each item, and explain further where indicated):

- As an adult, have you experienced any serious illnesses, medical problems, or head trauma? Yes / No  
If yes, please describe: \_\_\_\_\_
- Do you currently have any illnesses or medical problems? Yes / No  
If yes, please describe: \_\_\_\_\_
- Is your primary care physician aware of any existing medical problems? Yes / No

**Family Medical History:**

- Has anyone in your family ever had any major illnesses, medical problems, head trauma, or developmental problems? Yes / No  
If yes, please explain: \_\_\_\_\_

Rank/Name: \_\_\_\_\_

FMP/SSN: \_\_\_\_\_

**Medications**

List any medications you are currently taking or have taken within the last year (including over-the-counter medications, aspirin, laxatives, birth control pills, and alternative or herbal medicines)

Medication	Dosage	When	For what condition?

**Pain**

1. Do you experience physical pain on a regular basis? YES NO Type/Location of pain: \_\_\_\_\_

2. If yes, please rate the pain you are currently feeling:

0	1	2	3	4	5	6	7	8	9	10
No pain		Mild pain			Moderate pain			Severe pain		Extreme pain

**Allergies**

1. Are you allergic to any medications? YES NO

2. Are you allergic to any foods? YES NO

Substance:	Allergic Response:
Substance:	Allergic Response:

**IV. PERSONAL HISTORY**

**Family Background**

1. Where did you grow up? \_\_\_\_\_

2. Any significant past/current family problems? \_\_\_\_\_

Indicate if you experienced any of the following at any time in your life:

Verbal abuse	Domestic Violence	Unhappy Childhood
Physical abuse	Rape	Death of parent
Emotional abuse	Miscarriage	Death of a child
Sexual abuse	Abortion	Death of someone close
Witnessed physical abuse	Crime victim	Filed for bankruptcy
Witnessed emotional abuse	War	Teased by peers
Witnessed sexual abuse	Poverty	Natural disaster

**Education/Learning**

1. What is the highest education you have completed? GED High School Some College Bachelor's Graduate Degree

2. Please check any of the following that applied to you during your education (grade school, high school, and/or college) or currently

Low grades	Being involved in after school activities	Skipping a grade
High grades	Being held back a grade(s)	Few friends
Truancy	Being suspended or expelled	Many friends
Interactions with the law	Requiring special education	Difficulty reading or writing
Educational or learning problems	Fighting in school. If yes, how often:	

3. What is your learning preference? How do you learn best?

Visual (watching, reading)	Auditory (listening to tapes, others)	Hands-on (trying it yourself)
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**Current Family** (Circle your response to each item, and explain further where indicated):

- Marital Status: Single Married Divorced Widowed Separated
- Number of years married: \_\_\_\_\_ Total number of marriages: \_\_\_\_\_
- How satisfied are you with current family life? Very unsatisfied Unsatisfied Satisfied Very satisfied
- Briefly describe your current living situation (e.g., with whom you currently live) \_\_\_\_\_
- Are you experiencing any family problems or problems at home? (If yes, describe) \_\_\_\_\_
- Are you currently experiencing any physical, sexual, or emotional abuse? Yes / No

If yes, please describe: \_\_\_\_\_

Rank/Name: \_\_\_\_\_ FMP/SSN: \_\_\_\_\_

**Mental Health History** Indicate if at any time in your life you:

<input type="checkbox"/>	Had a Commander-Directed Evaluation	<input type="checkbox"/>	Had a substance abuse evaluation or treatment (ADAPT or other program)
<input type="checkbox"/>	Had a Family Advocacy evaluation or treatment	<input type="checkbox"/>	Saw a chaplain for counseling
<input type="checkbox"/>	Saw a school counselor for counseling	<input type="checkbox"/>	Were given medication for a mental health problem
<input type="checkbox"/>	Saw a physician for a mental health problem	<input type="checkbox"/>	Saw a psychiatrist, psychologist, social worker, or counselor for treatment (on or off base)
<input type="checkbox"/> Were hospitalized for mental or emotional problems (e.g., nervous breakdown, depression, suicide, mania, schizophrenia, anxiety, drug or alcohol problems, etc)			

**Family Mental Health History:**

Please check any mental health conditions that may apply to any of your family members. Enter appropriate letter(s) to indicate which family member after the condition (M=Mother, F=Father, S=Sister, B=Brother, A=Aunt, U=Uncle, GP=Grandparents).

<input type="checkbox"/>	Learning Disability	<input type="checkbox"/>	Attention Deficit/Hyperactivity Disorder (AD/HD) or Attention Deficit Disorder (ADD)
<input type="checkbox"/>	Psychosis (such as schizophrenia)	<input type="checkbox"/>	Bipolar Disorder or Manic Depression
<input type="checkbox"/>	Alcohol or Drug Abuse	<input type="checkbox"/>	Anxiety Disorder (such as panic disorder, phobia, or excessive worry)
<input type="checkbox"/>	Mental Retardation	<input type="checkbox"/>	Hospitalized for a mental health problem
<input type="checkbox"/>	Depression	<input type="checkbox"/>	Other:

**Religion/Spirituality**

1. Do you have a religious affiliation? Yes / No
2. Do you have any religious/ spiritual concerns? Yes / No

**V. OCCUPATION**

Job Title: \_\_\_\_\_ AFSC: \_\_\_\_\_ Time in Service: \_\_\_\_\_

Describe your duties at work: \_\_\_\_\_

How satisfied are you with your current job? Very unsatisfied Unsatisfied Satisfied Very satisfied

Has your current problem/concern affected your work? Yes / No

Have you received any disciplinary action at work? Yes / No

If yes, please explain: \_\_\_\_\_

Will you PCS/Deploy in the next year? **Yes / No** If yes, when \_\_\_\_\_

Are you planning to separate from the service? **Yes / No** If yes, when \_\_\_\_\_

Work/Military History (Dates of service, assignments, etc.): \_\_\_\_\_

\_\_\_\_\_

How many jobs have you held? \_\_\_\_\_ How many have you been fired from? \_\_\_\_\_

Deployment History (Dates and locations of deployments): \_\_\_\_\_

\_\_\_\_\_

**VI. LEGAL/FINANCIAL**

1. Are you currently experiencing any legal difficulties? Yes / No  
If yes, please explain: \_\_\_\_\_
2. Are you currently experiencing any financial difficulties? Yes / No  
If yes, please explain: \_\_\_\_\_
3. Are you currently experiencing difficulties paying your bills? Yes / No

**VII. HABITS**

**Tobacco/Caffeine**

1. Do you use tobacco products? Yes / No  
If yes, what kind? \_\_\_\_\_  
How much (e.g., # per day)? \_\_\_\_\_
2. Do you use caffeinated products (e.g., coffee, tea, soda, tablets, energy drinks)? Yes / No  
If yes, what kind? \_\_\_\_\_  
How much (e.g., servings per day)? \_\_\_\_\_

Rank/Name: \_\_\_\_\_ FMP/SSN: \_\_\_\_\_

- Drugs**
1. Have you ever overused any prescription or over-the-counter drug? Yes / No
  2. Have you used any illegal drugs now or in the past? Yes / No
  3. Have you ever taken drugs by IV, not prescribed by a physician? Yes / No

- Alcohol**
1. Do you drink alcohol now or have you in the past? **If yes, please continue.** Yes / No
  2. How many days out of the **month** do you drink? \_\_\_\_\_
  3. How much do you usually drink when you do drink?  
 # Glasses Wine \_\_\_\_\_ **and / or** # Beers \_\_\_\_\_ **and / or** # Shots of Liquor/Hard alcohol \_\_\_\_\_
  4. How many times per **month** do you drink to get drunk or to get away from stressors? \_\_\_\_\_
  5. Have you ever felt to should cut down on your drinking? Yes / No
  6. Have people annoyed you by criticizing your drinking? Yes / No
  7. Have you ever felt bad or guilty about your drinking? Yes / No
  8. Have you ever had a drink first thing in the morning (eye opener) to steady your nerves or get rid of a hangover? Yes / No
  9. Have you ever been in treatment for use of alcohol/illicit drugs (including ADAPT, AA, Rational Recovery, etc.)? Yes / No
  10. Have you had trouble with the law due to alcohol use (e.g., DUI, drinking underage, alcohol-related violence)? Yes / No
  11. Has your alcohol use increased in the past month? Yes / No
  12. Have you had problems in your personal relationships or at work due to alcohol use? Yes / No
  13. Have you ever driven after drinking alcohol? Yes / No
  14. Have you blacked out in the past from drinking alcohol? Yes / No

- Nutrition**
1. Do you have any nutritional concerns? Yes / No
  2. Do you have poor nutritional intake or involuntary weight loss? Yes / No
  3. Have you ever purged or restricted food intake to control your weight? Yes / No
  4. What was your last score category on the annual fitness test? **Poor Marginal Good Excellent**

- Other**
1. Do you engage in unprotected sex? Yes / No
  2. Are you having any difficulties controlling any behaviors, such as gambling or pornographic use? Yes / No

**VIII. COPING**

1. Who do you talk to about your problems? \_\_\_\_\_
2. What do you do when you're stressed? \_\_\_\_\_
3. What do you do when you're sad? \_\_\_\_\_
4. What do you do when you're angry? \_\_\_\_\_
5. How do you spend your free time? \_\_\_\_\_
6. What activities are fun for you? \_\_\_\_\_
7. Are you participating in those activities? Yes / No
8. Do you participate in any recreational activities that are unsafe? Yes / No  
 If yes, please explain: \_\_\_\_\_
9. How satisfied are you with your quality of life? Very unsatisfied Unsatisfied Satisfied Very satisfied

**TREATMENT GOALS**

- What are **YOUR** main goals for treatment? What would **YOU** like to change or to see different in your life?
1. \_\_\_\_\_
  2. \_\_\_\_\_
  3. \_\_\_\_\_

**Specific Goals**  
 In coming to this center, I would like to concentrate on..... (Check any that apply). Note the 3 most important goals with 1, 2, & 3.

Feeling less depressed	Feeling less anxious/fearful	Feeling less angry
Better managing my temper	Feeling more self-confident	Feeling less guilt
Better managing my health or pain	Doubting myself less	Better tolerating my mistakes
Having more fun	Better accepting a loss/death	Talking out a pending decision

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Discussing desire for separation/discharge	Learning how to relax	Thinking more positively
Not reacting so emotionally	Improving my sleep	Worrying less about... (complete the goal)
Better tolerating my mistakes	Expressing myself more assertively	Improving family relationship
Improving marital relationship	Improving work relationship	Improving communication skills
Improving relationship with....(complete the goal)	Improving my sexual relationship	Reducing my sensitivity to criticism
Controlling my eating or weight	Learning how I come across to others	Receiving medication help
Adjusting better to a recent change	Discussing thoughts of harming self	Allowing myself to express feelings more
Not taking disappointments so hard	Learning problem-solving techniques	Learning how to improve friendships
Adjusting better to a past incident	Discussing thoughts of harming others	Controlling my use of alcohol or drugs

**STAFF USE ONLY**

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_

Rank/Name: \_\_\_\_\_ FMP/SSN: \_\_\_\_\_