Greatland Clinical Associates

1400 W. Benson, Suite 315 Anchorage, Alaska 99503

Pre-Evaluation Questionnaire

To better help us serve you, please provide us with the following information prior to your evaluation with your clinician. All information is confidential and will be part of your clinical record. If you need more space feel free to use the back of the paper. Please feel free to ask us questions about any of the information requested. Thank you. (Attention: ***Parents*** *completing form, provide child's information)*

Date: _____

Name: _____ **DOB:** _____ **Gender: M / F**

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Other: _____

Please describe the main reason for your visit/current concerns: *including behaviors, thoughts, and feelings*

In what situations, at what time or day(s), in what place(s) does this occur?

How *often* do you feel this way or have this problem?

Rate the *intensity* of the problem on a scale of 1-10: 1 2 3 4 5 6 7 8 9 10

less intense more intense

Medical Information

Please be as specific as possible

Do you have any drug allergies? ☐ Yes ☐ No *If yes please list all drugs and the reactions they cause*:

Are you currently taking any medications? ☐ Yes ☐ No *If* yes, *please list all medications, dosages, times taken per day, and how long you have been taking them. (also include supplements (ie vitamins, herbs, etc.)*

Do you have any currently active medical illnesses? ☐ Yes ☐ No *If yes, please list them:*

Do you have a history of any other medical illnesses? ☐ Yes ☐ No *If yes, please list them*:

Have you had any surgeries? ☐ Yes ☐ No *If yes, please list the procedures, approximate dates, and any problems or complications*:

Obstetrical/Gynecological history: ☐ *Not applicable*

Number or pregnancies: _____

Number of children: _____

Date of my last menstrual period: _____

Was it normal?: ☐ Yes ☐ No *If no, please explain:*

Who is your Primary Care Physician? _____

Do you have a pharmacy that you prefer? ☐ Yes ☐ No _____

When was your last check-up? _____

Medical Information Continued

When was the last time you had any blood-work done? _____

Have you ever been knocked out or diagnosed with a concussion? ☐ Yes ☐ No *If yes, please explain:*

Have you ever had a seizure or undergone an EEG? ☐ Yes ☐ No *If yes, please explain:*

Have you ever had any neuro-imaging: (ie brain CT scan or MRI?) ☐ Yes ☐ No *If yes, please explain:*

What was your birth-weight? ☐ Can't recall _____

Are you aware of any pre-natal exposures: (*did your Mother drink or use any other substances while she was pregnant with you*?) ☐ Yes ☐ No ☐ Not sure *If yes, please explain:*

Are you aware of any problems with your own pregnancy? (*when your mother was pregnant with you, during or shortly after delivery*?) ☐ Yes ☐ No ☐ Not sure *If yes, please explain:*

Were you ever formally diagnosed with any developmental delays – *learning to talk (and requiring a speech therapist), or to walk, or motor coordination*? ☐ Yes ☐ No *If yes, please explain:*

Tell us about your *biological* family history: (*this will help us understand what health issues may be of concern to you*)

Do you have any *biologically related relatives* with a history of the following?

Depression? ☐ Yes ☐ No *If yes, who:*

Bipolar or *manic-depressive illness*? ☐ Yes ☐ No *If yes, who:*

Schizophrenia? ☐ Yes ☐ No *If yes, who:*

Anxiety disorders such as *Panic*, *Post-traumatic stress disorder*, or *OCD*? ☐ Yes ☐ No *If yes, who:*

Eating disorders such as *Anorexia Nervosa*, *Bulimia*, or *Binge Eating disorder*? ☐ Yes ☐ No *If yes, who:*

Addiction? ☐ Yes ☐ No *If yes, whom, what:*

☐ Alcohol
☐ Marijuana
☐ Cocaine
☐ Amphetamines
☐ IV drugs
☐ Prescription drugs
☐ Other drugs/substances: _____

General medical illnesses? ☐ Yes ☐ No *If yes, whom, what:*

Have you ever seen a psychiatrist? ☐ Yes ☐ No *If yes, who, where, and when:*

Have you ever seen a counselor or therapist? ☐ Yes ☐ No *If yes, who, where, and when*

Have you ever been diagnosed with a mental health condition? ☐ Yes ☐ No *If yes, please explain what diagnosis, when, and by whom:*

Have you ever been on psychiatric medications? ☐ Yes ☐ No *If yes, please list names, doses, and approximate dates*:

Have you ever been hospitalized for psychiatric reasons before? ☐ Yes ☐ No *If yes, please list location and dates*:

Have you ever attempted or seriously considered suicide? ☐ Yes ☐ No *If yes, when:*

Are you currently considering suicide? ☐ Yes ☐ No
Do you have a plan? ☐ Yes ☐ No

Current or Historical Substance Use

Do you currently use, or do you have a history of using in the past? *Please check those that apply*

☐ Tobacco/Chew/Nicotine gum or patch
☐ Caffeine/ *How Much* _____
☐ Alcohol
☐ Marijuana
☐ Cocaine
☐ IV drugs
☐ Inhalants
☐ Prescription drugs
☐ Heroin
☐ Amphetamines (include methamphetamine)
☐Hallucinogens
☐ Illicit prescription drugs (ie oxycontin)
☐ Other drugs/substances: _____

If you have a history or are currently using alcohol or other substances please answer the following questions: ☐ Not Applicable

Have you ever experienced withdrawal symptoms from alcohol or other drugs? ☐ Yes ☐ No

Has anyone ever told you that they thought you had a problem with drugs or alcohol? ☐ Yes ☐ No

Have you ever felt guilty about your drug or alcohol use? ☐ Yes ☐ No

Have you ever felt annoyed when someone talked to you about your drug or alcohol use? ☐ Yes ☐ No

Have you used drugs or alcohol first thing in the morning? ☐ Yes ☐ No

Social History

Where were you born and raised?

Do you have any siblings? *How many, gender, ages?*

Tell us about your educational history. *Currently in school, grades, difficulties, diploma, GED, degree(s) attained?*

Tell us about your work history? (*types of jobs have you held, where, what is your current employment status, military*)

Do you have any current legal involvement and/or history of legal involvement? ☐ Yes ☐ No
If yes, *please describe*

Have you ever been convicted of a crime (assault, DWI, theft)? ☐ Yes ☐ No
If yes, please describe (don't include parking or minor traffic tickets)

Have you experienced any significant traumas in your life? ☐ Yes ☐ No
If yes, please describe

Have you felt unsafe or at risk of violence in any of your relationships? ☐ Yes ☐ No
If yes, please describe

Is there any other relevant information which you would like to be sure we discuss during our interview time? *Please provide additional information*?