Northeast Georgia PHYSICIANS GROUP

Adult New Patient Questionnaire

Date: _____ Sex: M / F

Patient Name: _____ DOB: _____

Allergies: _____

What do you consider to be your top three stresses in life?

1. _____
2. _____
3. _____

Risk Assessment: (Please circle YES or NO)

1. Do you ever feel that you do not want to live anymore?	Yes	No			
2. If yes, do you have a specific plan to end your life? Explain please:	Yes	No			
3. Do you have access to any weapons?	Yes	No			
4. Have you ever done something to purposefully hurt yourself?	Yes	No			
5. Have you ever heard voices telling you to hurt yourself?	Yes	No			
6. Has anyone in your family committed suicide?	Yes	No			
7. Have you ever hurt someone or destroyed property on purpose?	Yes	No			
8. Have you ever been arrested or detained for violent behavior?	Yes	No			
9. Have you ever been to jail for any reason?	Yes	No			
10. Have you ever been on probation for any reason?	Yes	No			
11. Do you currently have problems with pain?	Yes	No			
12. Are your childhood events contributing to current problems?	Yes	No			
13. What is your current marital status?	Single	Married	Divorced	Widowed	Separated
14. Do you have any children?	Yes	No			
15. Have you experienced any abuse? (physical, sexual, verbal)	Yes	No			
16. How satisfied are you with your current family life?	Very Unsatisfied	Unsatisfied	Satisfied	Very Satisfied	
17. Are you working?	Yes	No			

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Alcohol Use:

1. Do you regularly use alcohol (more than twice per month)?
   In the past: Yes No Recently: Yes No
2. Have you had trouble (legal, work, family) because of alcohol?
   In the past: Yes No Recently: Yes No
3. Have you felt that you should cut down on your drinking?
   In the past: Yes No Recently: Yes No
4. Have you been annoyed by people criticizing your drinking?
   In the past: Yes No Recently: Yes No
5. Have you felt bad or guilty about your drinking?
   In the past: Yes No Recently: Yes No
6. Have you ever had a drink first thing in the morning?
   In the past: Yes No Recently: Yes No

Other Substance Use/Abuse:

1. Do you use medications (other than over the counter) that were not prescribed to you?
   In the past: Yes No Recently: Yes No
2. Have you taken more than the recommended daily dosage of an over the counter medication?
   In the past: Yes No Recently: Yes No
3. Have you taken more than the prescribed dose of your prescription medication?
   In the past: Yes No Recently: Yes No
4. Have you taken or used any illegal substance?
   In the past: Yes No Recently: Yes No
5. Have you used any product or other means to get "high"?
   In the past: Yes No Recently: Yes No

Habits:

1. Do you smoke or chew tobacco regularly? Yes No
2. How many caffeinated drinks to you have per day? (coffee, tea, soda) _____
3. Do you have problems with gambling? Yes No
4. Do you have other potentially harmful habits you want to change? Yes No
   If so, what? _____

Goals for Treatment:

What are your goals for treatment? In other words, what things would you like to see change or be different about yourself?

_____

_____

_____

_____

_____