Adult Integrative Psychiatry Questionnaire

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Name: _____

Date of Birth: _____ **Current Date**: _____

CURRENT ISSUES

What are the basic problem(s) you are seeking help for?

1. _____
2. _____
3. _____
4. _____

What are your treatment goals? _____

_____

_____

Current Psychiatric Symptoms Checklist: (check Symptoms you experience currently or frequently)

- ☐ **Depressed mood**
- ☐ **Unable to enjoy life**
- ☐ **Sleeping Too Much**
- ☐ **Sleeping Too Little**
- ☐ **Early Waking**
- ☐ **Trouble Falling Asleep**
- ☐ **Unable to enjoy life**
- ☐ **Loss of interest**
- ☐ **Memory Problems**
- ☐ **Excessive Guilty Feelings**
- ☐ **Fatigue / Decreased Energy**
- ☐ **Poor Concentration**
- ☐ **Increased Appetite**
- ☐ **Decreased Appetite**
- ☐ **Weight Loss**
- ☐ **Hearing Things / Psychosis**
- ☐ **Suicidal Feelings**
- ☐ **Decreased Sex Drive**
- ☐ **Crying spells**
- ☐ **Low Self-Esteem**
- ☐ **Feelings of Hopelessness**
- ☐ **Grandiosity**
- ☐ **Irritabilty**
- ☐ **Decrease need for sleep**
- ☐ **Rapid Speech**
- ☐ **Racing thoughts**
- ☐ **Distractibility**
- ☐ **Increased Drive**
- ☐ **Physical Agitation**
- ☐ **Increased Sex Drive**
- ☐ **Spending Too Much Money**
- ☐ **Increased Risk Taking**
- ☐ **Excessive Energy**
- ☐ **Excessive worry**
- ☐ **Feeling Restless/ Keyed Up**
- ☐ **Physical or Mental Fatigue**
- ☐ **Poor Concentration**
- ☐ **Irritability**
- ☐ **Muscle Tension**
- ☐ **Discrete Episode of Fear**
- ☐ **Racing Heart**
- ☐ **Sweating**
- ☐ **Trembling**
- ☐ **Shortness of Breath**
- ☐ **Feeling of Choking**
- ☐ **Chest Pain**
- ☐ **Nausea**
- ☐ **Dizziness**
- ☐ **Derealization**
- ☐ **Fear of being Crazy**
- ☐ **Fear of Dying**
- ☐ **Sensory Changes**
- ☐ **Chills or Hot Flushes**
- ☐ **Social Fears and Anxiety**
- ☐ **Avoidance of Social Events**
- ☐ **Obsessive Thinking**
- ☐ **Compulsive Behaviors**
- ☐ **Refusal to Maintain Weight**
- ☐ **Irrational Fear over Weight**
- ☐ **Disturbed Body Image**
- ☐ **Loss of Your Period**
- ☐ **Food Binging**
- ☐ **Purging or Restriction**
- ☐ **Hallucinations / Voices**
- ☐ **Delusions**
- ☐ **Disorganized Speech**
- ☐ **Disorganized Behavior**
- ☐ **Personality Blunting**
- ☐ **Concentration Trouble**
- ☐ **Careless Mistakes**
- ☐ **Can't Sustain Attention**
- ☐ **Poor Listening**
- ☐ **Failure to Finish**
- ☐ **Instructions Difficulty**
- ☐ **Poor Organizing Capacities**
- ☐ **Avoids Mental Effort**
- ☐ **Loses Things**
- ☐ **Easily Distracted**
- ☐ **Forgetful of daily activities**
- ☐ **Constant Fidgets /Tapping**
- ☐ **Getting Out of Seat**
- ☐ **Difficulty with Quiet Time**
- ☐ **Climbing**
- ☐ **Excessive Talking**
- ☐ **Difficultly Waiting for Turn**
- ☐ **Blurting out Answers**
- ☐ **Interrupts Others**
- ☐ **Poor Self Esteem**
- ☐ **Tendency to Frustration**
- ☐ **Quitting Easily**

Details Regarding the Above Symptoms: _____

_____

_____

_____

_____

SUICIDE RISK ASSESSMENT

Have you ever had feelings or thoughts that you didn't want to live? Y ☐ N ☐
If YES, please answer the following. If NO, please skip to ***Past Psychiatric History***
Do you **currently** feel that you don't want to live? Y ☐ N ☐
How often do you have these thoughts? _____
When was the last time you had thoughts of dying? _____
Has anything happened recently to make you feel this way? _____
On a scale of 1 to 10, (ten being strongest) how strong is your desire to kill yourself currently? _____
Would anything make it better? _____
Have you ever thought about how you would kill yourself? Y ☐ N ☐ Details: _____
Is the method you would use readily available? Y ☐ N ☐
Have you planned a time for this? Y ☐ N ☐ Details: _____
Is there anything that would stop you from killing yourself? Y ☐ N ☐ Details: _____
Do you feel hopeless and /or worthless? Y ☐ N ☐
Have ever tried to kill or harm yourself before? Y ☐ N ☐ Details: _____

PAST PSYCHIATRIC HISTORY

Have you previously engaged outpatient psychiatric treatment? Y ☐ N ☐
Details: _____
_____

Have you ever been in the psychiatric hospital? Y ☐ N ☐
Details: _____
_____

PERSONAL and FAMILY PAST PSYCH HISTORY:

Have you or a member of your family had of any of the following Diagnoses or Conditions?

Diagnosis / Condition	You		Family	Details (if not explained elsewhere)
	Now	Past		
Depression	☐	☐	☐	
Suicidal Feeling	☐	☐	☐	
Suicide Attempt	☐	☐	☐	
Bipolar Disorder	☐	☐	☐	
Anxiety	☐	☐	☐	
Panic	☐	☐	☐	
Phobias	☐	☐	☐	
PTSD	☐	☐	☐	
Alcoholism	☐	☐	☐	
Drug Addiction	☐	☐	☐	
Assault/Rage	☐	☐	☐	
Psychosis	☐	☐	☐	
Schizophrenia	☐	☐	☐	
Anorexia	☐	☐	☐	
Bulemia	☐	☐	☐	
OCD	☐	☐	☐	
Hoarding	☐	☐	☐	
Dementia	☐	☐	☐	
ADHD	☐	☐	☐	
Dyslexia	☐	☐	☐	
Learning Disability	☐	☐	☐	
Autism/Asperger's	☐	☐	☐	
Other:	☐	☐	☐	
Other:	☐	☐	☐	

Past Psychiatric Medications: please check past medications and indicate the details below.

Antidepressants

☐Prozac (fluoxetine) - ☐Zoloft (sertraline) - ☐Luvox (fluvoxamine) - ☐Paxil (paroxetine) - ☐Celexa (citalopram) – ☐Lexapro (escitalopram) - ☐Effexor (venlafaxine) - ☐Cymbalta (duloxetine) - ☐Wellbutrin (bupropion) - ☐Remeron (mirtazapine) – ☐Vybrid (vilazodone) – ☐Parnate (trancypromine) – ☐Emsam (selegiline) - ☐Serzone (nefazodone) – ☐Anafranil (clomipramine) - ☐Pamelor (nortrptyline) - ☐Tofranil (imipramine) - ☐Elavil (amitriptyline) - ☐Deplin (methyfolate)

Mood Stabilizers

☐Tegretol (carbamazepine) - ☐Lithium - ☐Depakote (valproate) - ☐Lamictal (lamotrigine) - ☐Tegretol (carbamazepine) ☐Trileptal (oxcarbamazipine) - ☐Topamax (topiramate)

Antipsychotics/Mood Stabilizers

☐Seroquel (quetiapine) - ☐Zyprexa (olanzepine) - ☐Geodon (ziprasidone) - ☐Abilify (aripiprazole) - ☐Clozaril (clozapine) – ☐Fanapt (iloperidone) – ☐Saphris (asenapine) – ☐Latuda (lurasidone) – ☐Invega (paliperidone) - ☐Haldol (haloperidol) - ☐Prolixin (fluphenazine)

Sedative/Hypnotics and Anti-anxiety

☐Ambien (zolpidem) – ☐Lunesta (eszolpiclone) - ☐Sonata (zaleplon) - ☐Rozerem (ramelteon) - ☐Restoril (temazepam) ☐Desyrel (trazodone) - ☐Xanax (alprazolam) - ☐Ativan (lorazepam) - ☐Klonopin (clonazepam) - ☐Valium (diazepam) - ☐Buspar (buspirone)

ADHD medications

☐Adderall (amphetamine) – ☐Vyvanse (lisdexamphetamine) - ☐Concerta (methylphenidate) - ☐Ritalin (methylphenidate) ☐Strattera (atomoxetine) - ☐Selegiline

Past Medication	Dosage	Effects / Response	Side Effects

Has any family member been treated with psychiatric medications? Y ☐ N ☐

Details: _____

_____

MEDICAL HISTORY

Approximate Date and place of last physical exam: _____

All current MEDICATIONS (Prescription and OTC):

Medication Name	Dosage	Directions	Side Effects

All current SUPPLEMENTS, HERBS or NUTRIENTS:

Supplement Name	Dosage	Directions	Effects and Side Effects

Current and Past MEDICAL CONDITIONS and SURGERIES:

Medical Condition	Current		For How Long? Details.
	Y	N	
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	

Have you ever had an EKG? Y ☐ N ☐ If yes, when? _____
Why? _____ Was the EKG: ☐ Normal ☐ Abnormal ☐ Unknown**?**
Have you ever had an MRI or CAT Scan? Y ☐ N ☐ If yes, when? _____
Why? _____ Was the scan ☐ Normal ☐ Abnormal ☐ Unknown**?**

Your Exercise Level:
Do you exercise regularly? Y ☐ N ☐
How many days a week do you get exercise? _____
What kind of exercise do you get? _____
Do you feel better with exercise? Y ☐ N ☐
Do you feel "wiped out" or recover very slowly with exercise? Y ☐ N ☐

Diet:
Do you eat meat? Y ☐ N ☐ Vegan? Y ☐ N ☐ Vegetarian Y ☐ N ☐ Organic? Y ☐ N ☐
How many servings of Vegetables _____ and Fruits _____ do you get on average every day?
How many caffeinated beverages do you drink a day? _____ Coffee _____ Sodas _____ Tea _____

Tobacco History:
Have you smoked cigarettes regularly? Y ☐ N ☐ Currently? Y ☐ N ☐
Packs per day on average? _____ How many years? _____ When did you quit? _____
Use pipe, cigars, or chewing tobacco currently? Y ☐ N ☐
What kind? _____ How often per day on average? _____ How many years? _____

For Women Only:

Are you currently pregnant or do you think you might be pregnant? Y ☐ N ☐
Are you planning to be pregnant soon? Y ☐ N ☐ Birth control method: _____
How many times have you been pregnant? _____ How many live births? _____
Is menstrual cycle irregular? Y ☐ N ☐ Details: _____
Is your menstrual cycle regular without birth control pills? Y ☐ N ☐
What is your Pattern? Every _____ days, Light ☐ Medium ☐ Heavy ☐, lasting _____ days.
Have you ever had Ovarian Cysts? Y ☐ N ☐ Details: _____
Do you or did you get Acne? Y ☐ N ☐ Details: _____
Do your Mood Symptoms worsen at a specific time in your cycle? Y ☐ N ☐
Details**:** _____

Were there any complications during your birth or your mother's pregnancy?
Details: _____

Describe your SLEEP patterns: _____

Do you ever get night sweats? Y ☐ N ☐ Do you wake up with a pounding heart? Y ☐ N ☐
How many hours before bedtime do you eat? _____ Are your legs uncomfortable in bed? Y ☐ N ☐
Do you stop breathing while you sleep? Y ☐ N ☐ Do you ever wake up gasping for breath? Y ☐ N ☐
Can you breathe easily through your nose? Y ☐ N ☐ "Walk off" leg discomfort at bed? Y ☐ N ☐
If you didn't need to get up at a specific time would you start going to bed later and later? Y ☐ N ☐
Do you resist falling asleep only to get a "second wind" . . . that you are no longer tired? Y ☐ N ☐
How long does it take to feel awake in the morning? _____
Do you feel in the morning as if you were barely asleep the whole night? Y ☐ N ☐
Has anything bad happened in the past while you were sleeping? Y ☐ N ☐

Substance Use:

Have you ever been treated for alcohol or drug use or abuse? Y ☐ N ☐
How many days per week do you drink alcohol? _____
What is the least number of drinks you will drink in a day? _____
The most? _____
Consequences? ☐ Blackouts ☐ Withdrawal ☐ DUI ☐ Relationship ☐ Job ☐ Health
Have you ever felt you ought to cut down on your drinking or drug use? Y ☐ N ☐
Have people annoyed you by criticizing your drinking or drug use? Y ☐ N ☐
Have you ever felt bad or guilty about your drinking or drug use? Y ☐ N ☐
Do you drink or used drugs in the morning to steady your nerves? Y ☐ N ☐
Do you think you may have a problem with alcohol or drug use? Y ☐ N ☐
Is Marijuana a problem for you? Y ☐ N ☐

Check if you have ever used or had trouble with, or simply want to discuss any of the following:

☐ Methamphetamine	☐ Cocaine	☐ Stimulants (pills)	☐ Heroin	☐ Pain killers
☐ Vicodin	☐ Methadone	☐ Oxycontin	☐ LSD	☐ Mushrooms
☐ Ecstasy	☐ Ketamine	☐ Marijuana	☐ Tranquilizers	☐ Sleeping pills
☐ Klonopin	☐ Xanax	☐ Valium	☐ Other – Details: _____	

Have any specific drugs made you feel better? Details: _____
Have any specific drugs made you feel worse? Details: _____

MEDICAL CHECKLIST / REVIEW OF SYSTEMS

Condition	You		Family Member?	Condition	You		Family Member?
	Now	Past			Now	Past	
Anemia	☐	☐	☐	Cancer:	☐	☐	☐
Low B12	☐	☐	☐	Cancer:	☐	☐	☐
Low Iron	☐	☐	☐	Low Cholesterol	☐	☐	☐
Chronic Fatigue	☐	☐	☐	High Cholesterol	☐	☐	☐
Dizzy when Standing	☐	☐	☐	Obesity/Overweight	☐	☐	☐
Blood Sugar Lows	☐	☐	☐	Weight Loss	☐	☐	☐
Trouble Waking in Morn	☐	☐	☐	Heart Disease	☐	☐	☐
Poor exercise tolerance	☐	☐	☐	Heart Attack/MI	☐	☐	☐
Energy Peaks in Eve	☐	☐	☐	High blood pressure	☐	☐	☐
Hives	☐	☐	☐	Chest Pain	☐	☐	☐
Skin Itching	☐	☐	☐	Palpitations	☐	☐	☐
Eczema	☐	☐	☐	Heart Attack	☐	☐	☐
Psoriasis	☐	☐	☐	Irregular Heartbeat	☐	☐	☐
Fibromyalgia	☐	☐	☐	Hemophilia	☐	☐	☐
Non-restful sleep	☐	☐	☐	Easy Bruising	☐	☐	☐
Restless legs at Sleep	☐	☐	☐	Liver Disease	☐	☐	☐
Aching Legs at Rest	☐	☐	☐	Thyroid Disease	☐	☐	☐
Ulcers / Gastritic	☐	☐	☐	Sig weight gain	☐	☐	☐
Acid Reflux	☐	☐	☐	Tendency to be cold	☐	☐	☐
Constipation	☐	☐	☐	Sleep Apnea	☐	☐	☐
Diarrhea	☐	☐	☐	Sleep Attacks in Day	☐	☐	☐
Bloating	☐	☐	☐	Daytime Sleepiness	☐	☐	☐
Migraines	☐	☐	☐	Diabetes	☐	☐	☐
Food Allergies	☐	☐	☐	Frequesnt Urination	☐	☐	☐
Frequent Antibiotics	☐	☐	☐	Chronic Pain	☐	☐	☐
Sinusitis	☐	☐	☐	Epilepsy/Seizures	☐	☐	☐
Frequent UTIs	☐	☐	☐	Head trauma/injury	☐	☐	☐
Frequent Yeast Infxns	☐	☐	☐	Polycystic Ovaries	☐	☐	☐
Asthma/Respiratory	☐	☐	☐	Irregular Period	☐	☐	☐
Easily get Colds	☐	☐	☐	Significant Weight Flux	☐	☐	☐
Frequent Strep Throat	☐	☐	☐	Hair on chin (women)	☐	☐	☐
Serious Infection	☐	☐	☐	Kidney Disease	☐	☐	☐
Mono/EpsteinBarr Virus	☐	☐	☐	Pain with Urination	☐	☐	☐
Weight Loss	☐	☐	☐	Difficulty Urinating	☐	☐	☐
Unexplained Fevers	☐	☐	☐	Pain with Orgasm	☐	☐	☐
Diabetes	☐	☐	☐	Frequent Waking to Pee	☐	☐	☐
Excessive Thirst	☐	☐	☐	Other:	☐	☐	☐
Other:	☐	☐	☐	Other:	☐	☐	☐
Other:	☐	☐	☐	Other:	☐	☐	☐

Details (if not explained elsewhere): _____
_____
_____
_____
_____

FAMILY BACKGROUND and CHILDHOOD HISTORY

Background: Were you adopted? Y ☐ N ☐
Where did you grow up? _____
List your siblings and their ages: _____
Father's occupation? _____ Mother's Occupation? _____
Did your parents' divorce? Y ☐ N ☐ If so, how old were you when they divorced? _____
Describe your father and your relationship with him: _____
Describe your mother and your relationship with her: _____

Trauma History:
Do you have a history of being abused emotionally, sexually, physically or by neglect? Y ☐ N ☐
Details (if you are comfortable writing . . . or can discuss in office): _____

Educational History:
Did you attend college? Y ☐ N ☐ Where? _____ Major? _____
What is your highest educational level or degree attained? _____

Occupational History:
Are you currently: ☐ Working ☐ Not working by choice ☐ Unemployed ☐ Disabled ☐ Retired
How long in present position? _____
What is/was your occupation? _____
Are you happy with your work? _____

Relationship History and Current Family:
Are you currently: ☐ Married ☐ Divorced ☐ Single ☐ Widowed Details: _____
If not married, are you currently in a relationship? Y ☐ N ☐ How long? _____
Are you sexually active? Y ☐ N ☐
How would you identify your sexual orientation? ☐straight/heterosexual ☐lesbian/gay/homosexual
☐bisexual ☐transsexual ☐unsure/questioning ☐asexual ☐other ☐prefer not to answer
What is your spouse or significant other's occupation? _____
Describe your relationship with your spouse or significant other: _____
_____
Have you had any prior marriages? Y ☐ N ☐ If so, how many? _____
Describe any details regarding your marriage that are relevant: _____
Children? Y ☐ N ☐ How many? _____ What are their ages? _____
Describe your relationship with your children: _____

Legal: Have you ever been arrested? Y ☐ N ☐
Do you have any pending legal problems? Y ☐ N ☐ Details: _____

Spiritual life: Do you belong to a religion or spiritual group? Y ☐ N ☐ Which? _____
Have you ever had experiences of "Awe" or "Transcendence"? Y ☐ N ☐
Details: _____

Is there anything else that you would like your doctor to know? _____
_____
_____
_____

Emotional Distress – Anxiety – Short Form 8a

PROMIS Item Bank v1.0 – Emotional Distress – Anxiety – Short Form 8a
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Please respond to each question or statement by marking one box per row.

In the past 7 days…		Never	Rarely	Sometimes	Often	Always
EDANX01 1	I felt fearful	☐1	☐2	☐3	☐4	☐5
EDANX40 2	I found it hard to focus on anything other than my anxiety	☐1	☐2	☐3	☐4	☐5
EDANX41 3	My worries overwhelmed me	☐1	☐2	☐3	☐4	☐5
EDANX53 4	I felt uneasy	☐1	☐2	☐3	☐4	☐5
EDANX46 5	I felt nervous	☐1	☐2	☐3	☐4	☐5
EDANX07 6	I felt like I needed help for my anxiety	☐1	☐2	☐3	☐4	☐5
EDANX05 7	I felt anxious	☐1	☐2	☐3	☐4	☐5
EDANX54 8	I felt tense	☐1	☐2	☐3	☐4	☐5

Emotional Distress – Depression – Short Form 8a

Please respond to each question or statement by marking one box per row.

In the past 7 days…		Never	Rarely	Sometimes	Often	Always
EDDEP041	I felt worthless	☐1	☐2	☐3	☐4	☐5
EDDEP062	I felt helpless	☐1	☐2	☐3	☐4	☐5
EDDEP293	I felt depressed	☐1	☐2	☐3	☐4	☐5
EDDEP414	I felt hopeless	☐1	☐2	☐3	☐4	☐5
EDDEP225	I felt like a failure	☐1	☐2	☐3	☐4	☐5
EDDEP366	I felt unhappy	☐1	☐2	☐3	☐4	☐5
EDDEP057	I felt that I had nothing to look forward to	☐1	☐2	☐3	☐4	☐5
EDDEP098	I felt that nothing could cheer me up	☐1	☐2	☐3	☐4	☐5

Fatigue – Short Form 8a

PROMIS Item Bank v1.0 – Fatigue – Short Form 8a

Please respond to each question or statement by marking one box per row.

During the past 7 days…		**Not at all**	**A little bit**	**Somewhat**	**Quite a bit**	**Very much**
HI71	I feel fatigued	☐1	☐2	☐3	☐4	☐5
AN32	I have trouble starting things because I am tired	☐1	☐2	☐3	☐4	☐5
In the past 7 days…						
FATEXP413	How run-down did you feel on average? ...	☐1	☐2	☐3	☐4	☐5
FATEXP404	How fatigued were you on average?	☐1	☐2	☐3	☐4	☐5
FATEXP355	How much were you bothered by your fatigue on average?	☐1	☐2	☐3	☐4	☐5
FATIMP496	To what degree did your fatigue interfere with your physical functioning?	☐1	☐2	☐3	☐4	☐5
In the past 7 days…		**Never**	**Rarely**	**Sometimes**	**Often**	**Always**
FATIMP37	How often did you have to push yourself to get things done because of your fatigue?	☐1	☐2	☐3	☐4	☐5
FATIMP168	How often did you have trouble finishing things because of your fatigue?	☐1	☐2	☐3	☐4	☐5

Sleep Disturbance – Short Form 8a

Please respond to each question or statement by marking one box per row.

In the past 7 days…		**Very poor**	**Poor**	**Fair**	**Good**	**Very good**
Sleep1091	My sleep quality was	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
In the past 7 days…		**Not at all**	**A little bit**	**Somewhat**	**Quite a bit**	**Very much**
Sleep1162	My sleep was refreshing.	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Sleep203	I had a problem with my sleep	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Sleep444	I had difficulty falling asleep	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Sleep1085	My sleep was restless	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Sleep726	I tried hard to get to sleep	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Sleep677	I worried about not being able to fall asleep	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Sleep1158	I was satisfied with my sleep.	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1