Center for Integrative Psychiatry
580 S Denton Tap Rd, Suite 280
Coppell, TX - 75019-4005

*New Patient Questionnaire

How did you hear about our clinic? *

- ☐ Referred by a healthcare provider
- ☐ Referred by a friend/family member
- ☐ Insurance directory
- ☐ Online search
- ☐ Social media

If referred by a healthcare provider (please specify name of provider and clinic) or if referred by a friend/family member (please specify)

Main concern you'd like to discuss at your appointment (e.g., anxiety, depression, mood changes) *

Personal Details

First Name *

Last Name *

Date of Birth *

Gender

- ☐ Male
- ☐ Female
- ☐ Unknown

Language

Race

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White

Ethnicity

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Marital Status

- ☐ Single
- ☐ Married
- ☐ Others

Smoking Status

- ☐ Current every day smoker
- ☐ Current some day smoker
- ☐ Former Smoker
- ☐ Never Smoker
- ☐ Smoker
- ☐ current status unknown
- ☐ Unknown if ever smoked

Primary Contact Details

Caregiver First Name

Caregiver Last Name

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Email *

Home Phone

Mobile Phone

Work Phone

Fax

Primary Phone * ☐ Mobile Phone ☐ Home Phone ☐ Work Phone

Address Line1 *

Address Line2

City *

Country *

State *

Zip code *

Postbox No

Emergency Contact Name

Emergency Contact Number

Extn

Emergency Contact

Name: *

Contact number: *

Allergies

Allergies	Type	Severity	Reactions

Supplements

Supplement Name	Intake Details

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History of Present Illness

Depressive Symptoms

- [ ] Denied
- [ ] Reported
  - [ ] 2 weeks at least
  - [ ] Depressed mood
  - [ ] Interests, low
  - [ ] Guilt/worthlessness
  - [ ] Energy, low
  - [ ] Concentration, low
  - [ ] Sleep
    - [ ] Increased
    - [ ] Decreased
    - [ ] Unchanged
  - [ ] Appetite
    - [ ] Increased
    - [ ] Decreased
    - [ ] Unchanged
  - [ ] Weight
    - [ ] Increased
    - [ ] Decreased
    - [ ] Unchanged
  - [ ] Psychomotor slowing
  - [ ] SI
    - [ ] Denied
    - [ ] Admitted, See Notes
  - [ ] HI
    - [ ] Denied
    - [ ] Admitted, See Notes

Manic Symptoms

- [ ] Denied
- [ ] Reported
  - [ ] 1 week consecutively
  - [ ] Grandiose
  - [ ] Increased GD Activity
  - [ ] Decreased judgment
  - [ ] Distractible
  - [ ] Irritable
  - [ ] Decreased need for sleep
  - [ ] Elevated mood
  - [ ] Pressured Speech
  - [ ] Racing thoughts
  - [ ] Destructive impulsivity
    - [ ] Drugs
    - [ ] Driving
    - [ ] Sexual
    - [ ] Spending

Psychotic Symptoms

- [ ] Denied
- [ ] Reported
  - [ ] AH
  - [ ] VH
  - [ ] Delusions
  - [ ] Ideas of reference
  - [ ] Thought blocking or insertion
  - [ ] Disorganized Behavior
  - [ ] Disorganized Speech

Attentional/Hyperactive/Impulsive Symptoms

- [ ] Denied
- [ ] INATTENTION
  - [ ] Denied
  - [ ] Makes careless mistakes/lacks attention to detail
  - [ ] Difficulty sustaining attention
  - [ ] Does not seem to listen when spoken to directly
  - [ ] Fails to follow through on tasks and instructions
  - [ ] Exhibits poor organization
  - [ ] Avoids/dislikes tasks requiring sustained mental effort
  - [ ] Loses things necessary for tasks/activities
  - [ ] Easily distracted (including unrelated thoughts)
  - [ ] Is forgetful in daily activities
- [ ] HYPERACTIVITY
  - [ ] Denied
  - [ ] Fidgets with or taps hands or feet, squirms in seat
  - [ ] Leaves seat in situations when remaining seated is expected
  - [ ] Experiences feelings of restlessness
  - [ ] Has difficulty engaging in quiet, leisurely activities
  - [ ] Is “on-the-go” or acts as if “driven by a motor”
  - [ ] Talks excessively
- [ ] IMPULSIVITY
  - [ ] Denied
  - [ ] Blurts out answers
  - [ ] Has difficulty waiting their turn
  - [ ] Interrupts or intrudes on others

Panic Symptoms

- [ ] Denied
- [ ] Reported
  - [ ] Trembling/shaking
  - [ ] Palpitations/CP
  - [ ] Nausea
  - [ ] Choking/SOB
  - [ ] Sweating
  - [ ] Fear of dying or going crazy
  - [ ] Tingling
  - [ ] Hot/cold flushes
  - [ ] Agoraphobia

Generalized Anxiety Symptoms

- [ ] Denied
- [ ] Reported
  - [ ] Excessive Worry
  - [ ] Restless/edgy
  - [ ] Easily fatigued
  - [ ] Muscle tension
  - [ ] Less Sleep
  - [ ] Less concentration

Post Traumatic Symptoms

- [ ] Denied
- [ ] Reported
  - [ ] Experienced trauma
  - [ ] Persistent re-experiencing
  - [ ] Avoidance Behaviors
  - [ ] Hyperarousal

Eating Disorder Symptoms

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Past Medical History

Past Psychiatric History? ☐ Yes ☐ No

Comments _____

Past Medical History? ☐ Yes ☐ No

Comments _____

Past Medications: Please list ALL medications you have been on in the past

Name of Medication	Dose	Why did you stop this medication?	Did it help?

Current Medications: Please list ALL current medications

Medication name	Dose	How many times a day	Is it effective	Any side effects	When did you start this medication	Do you often miss doses of this medication

H/O Head Injury or Seizures or TBI? ☐ Yes ☐ No

Comments _____

Allergies? ☐ Yes ☐ No

Comments _____

Family History

Family History? ☐ Yes ☐ No

Comments _____

Social History

Tobacco

- [ ] Denied
- [ ] Reported
  - [ ] 0.5 PPD
  - [ ] 1 PPD
  - [ ] 1.5 PPD
  - [ ] 2 PPD
  - [ ] >2 PPD
  - [ ] Chewing Tobacco
  - [ ] Other

Alcohol

- [ ] Denied
- [ ] Reported
  - [ ] Occasional drinker
  - [ ] Moderate drinker
  - [ ] Heavy drinker

Substances, Other

- [ ] Denied
- [ ] Reported
  - [ ] THC
  - [ ] Crack/cocaine
  - [ ] Heroin
  - [ ] Ecstacy
  - [ ] Methamphetamines
  - [ ] Bath Salts
  - [ ] Opiates
  - [ ] Benzodiazepines
  - [ ] Other

Abuse and Trauma

- [ ] Denied
- [ ] Reported
  - [ ] Physical
  - [ ] Sexual
  - [ ] Emotional
  - [ ] Other Exposure, See Notes

- [ ] Pertinent Military Service, See Notes
- [ ] Pertinent Legal issues, See Notes
- [ ] Pertinent Work history, See Notes
- [ ] Pertinent School history, See Notes

Current Living Arrangements

- [ ] Homeless
- [ ] Owns House
- [ ] Responsible Party for a Rental House or Apt
- [ ] Lives Alone
- [ ] L/W Spouse
- [ ] Single, Divorced, Separated, Widowed,
- [ ] L/W Children
- [ ] Other
- [ ] Other _____

Comments _____

Preferred pharmacy (please provide complete address): *