AUDIT-C Questionnaire

Patient Name_____Date of Visit _____

1. **How often do you have a drink containing alcohol?**
   - ☐ a. Never
   - ☐ b. Monthly or less
   - ☐ c. 2-4 times a month
   - ☐ d. 2-3 times a week
   - ☐ e. 4 or more times a week

2. **How many standard drinks containing alcohol do you have on a typical day?**
   - ☐ a. 1 or 2
   - ☐ b. 3 or 4
   - ☐ c. 5 or 6
   - ☐ d. 7 to 9
   - ☐ e. 10 or more

3. **How often do you have six or more drinks on one occasion?**
   - ☐ a. Never
   - ☐ b. Less than monthly
   - ☐ c. Monthly
   - ☐ d. Weekly
   - ☐ e. Daily or almost daily

Affix Patient Label Here

Drug Abuse Screening Test (DAST-10)

The following questions concern information about your possible involvement with drugs not including alcoholic beverages or nicotine during the past 12 months.

"Drug abuse" refers to (1) the use of prescribed or over-the-counter drugs in excess of the directions, and (2) any nonmedical use of drugs.

The various classes of drugs may include cannabis, tranquilizers (e.g. Valium), barbiturates, cocaine, stimulants (e.g. methamphetamine), hallucinogens (e.g. LSD), opioids (e.g. non-medical use of drugs such as OxyContin or use of heroin) or solvents (e.g. paint thinner). Remember that the questions do not include alcoholic beverages or nicotine.

In the past 12 months…			
1.	Have you used drugs other than those required for medical reasons?	Yes	No
2.	Do you abuse more than one drug at a time?	Yes	No
3.	Are you unable to stop abusing drugs when you want to?	Yes	No
4.	Have you ever had blackouts or flashbacks as a result of drug use?	Yes	No
5.	Do you ever feel bad or guilty about your drug use?	Yes	No
6.	Does your spouse (or parents) ever complain about your involvement with drugs?	Yes	No
7.	Have you neglected your family because of your use of drugs?	Yes	No
8.	Have you ever engaged in illegal activities in order to obtain drugs?	Yes	No
9.	Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
10.	Have you ever had medical problems as a result of your drug use (such as memory loss, hepatitis, convulsions, bleeding)?	Yes	No

Constitution:	Yes	No
Fever	☐	☐
Chills	☐	☐
Weight loss	☐	☐
Malaise/fatigue	☐	☐
Sweating	☐	☐
Weakness	☐	☐

Skin:		
Rash	☐	☐
Itching	☐	☐

Head, ear, nose and throat:		
Hearing loss	☐	☐
Ringing in the ears	☐	☐
Ear pain	☐	☐
Nosebleeds	☐	☐
Congestion	☐	☐
Sinus pain	☐	☐
Noisy breathing	☐	☐
Sore throat	☐	☐

Eyes:		
Blurred vision	☐	☐
Double vision	☐	☐
Light sensitivity	☐	☐
Eye pain	☐	☐
Eye discharge	☐	☐
Eye redness	☐	☐

Cardiovascular:		
Chest pain	☐	☐
Palpitations	☐	☐
Shortness of breath when lying down	☐	☐
Leg pain	☐	☐
Leg swelling	☐	☐
Difficulty breathing that wakes you from sleep	☐	☐

Respiratory:		
Cough	☐	☐
Coughing up blood	☐	☐
Coughing up phlegm	☐	☐
Shortness of breath	☐	☐
Wheezing	☐	☐

Gastrointestinal:		
Heartburn	☐	☐
Nausea	☐	☐
Vomiting	☐	☐

Abdominal pain:	Yes	No
Diarrhea	☐	☐
Constipation	☐	☐
Blood in stool	☐	☐
Black tarry stool	☐	☐

Genitourinary:		
Urinary pain	☐	☐
Urinary urgency	☐	☐
Urinary frequency	☐	☐
Blood in urine	☐	☐
Flank pain	☐	☐

Musculoskeletal:		
Muscle pain	☐	☐
Neck pain	☐	☐
Back pain	☐	☐
Joint pain	☐	☐
Falls	☐	☐

Endocrine/hematology/allergy:		
Easy bruising/bleeding	☐	☐
Environmental allergies	☐	☐
Increased thirst	☐	☐

Neurological:		
Dizziness	☐	☐
Headaches	☐	☐
Tingling	☐	☐
Tremor	☐	☐
Sensory change	☐	☐
Speech change	☐	☐
Weakness	☐	☐
Seizures	☐	☐
Loss of consciousness	☐	☐

Psychiatric:		
Sadness, low mood	☐	☐
Self harm/cutting	☐	☐
Suicidal thoughts	☐	☐
Suicide attempts	☐	☐
Sleeping too much	☐	☐
Difficulty sleeping	☐	☐
Anxiety	☐	☐
Panic attacks	☐	☐
Memory loss	☐	☐

NEW PATIENT INFORMATION

NOTE: This form is not intended to be comprehensive. It simply serves as a *checklist of important topics* to discuss in-depth during our appointments. Please do not feel the need to provide great detail. If you prefer to wait until our appointment to discuss a particular topic, please leave that section blank.

What is the main reason you are here today?

I: PAST PSYCHIATRIC HISTORY:

1) Please list all previous psychiatrists or psychiatric ARNPs, with approximate dates of service.

   Name of Provider **Date**

   _____
   _____
   _____
   _____

2) Please list all previous therapists or counselors, with approximate dates of service.

   Name of Provider **Date**

   _____
   _____
   _____
   _____

Have you ever been treated for any of the following?

☐ Depression	☐ Anxiety	☐ Panic attacks
☐ Eating disorder	☐ ADHD	☐ OCD
☐ PTSD	☐ Bipolar Disorder	☐ Schizophrenia
☐ Alcohol problems	☐ Drug problems	☐ ECT treatment

3) Please provide information about **previous** trials of medications:

Medication Name	Approx. Date	Dosage	Helpful?	Side Effects?
			Yes / No	Yes / No
			Yes / No	Yes / No
			Yes / No	Yes / No
			Yes / No	Yes / No

4) Please list all psychiatric hospitalizations:
   Name of Hospital **Date**
   _____
   _____
   _____
   _____

5) What other treatments and remedies have you pursued to treat mental health symptoms?

Have you ever experienced the following:

Feelings of hopelessness and that life is not worth living: ☐ No ☐ Yes
Thoughts of actually hurting yourself: ☐ No ☐ Yes
Plan to hurt yourself: ☐ No ☐ Yes
Suicide attempts: ☐ No ☐ Yes → Date: _____
Do you self-harm? ☐ No ☐ Yes → please fill out below

- ☐ Cutting
- ☐ Burning
- ☐ Other: _____

II: PAST MEDICAL HISTORY:

1) Who is your Primary Care Physician (PCP)? _____
2) Do you get care anywhere other than the University of Washington on a regular basis?

3) Please list all active health conditions.

4) Please list all major past health conditions.

III: Current MEDICATIONS (please list all meds and doses)

Medication Name **Dosage**

_____
_____
_____
_____
_____
_____

IV: ALLERGIES (please list all medication, food, and other allergies):

V: FAMILY PSYCHIATRIC HISTORY (please list all diagnosed or suspected mental health disorders, suicide attempts, and substance abuse disorders occurring in your grandparents, parents, siblings, and children)

Do you have a family history of psychiatric conditions? ☐ No ☐ Yes → please fill below

Conditions	**Relation to Family Member**
Schizophrenia	
Bipolar Disorder	
Depression	
Anxiety	
Substance Abuse Disorder	
Suicide Attempts	
Obsessive Compulsive Disorder	
Other	

VI: SUBSTANCE USE

Substances	**Currently Use?**	**Amount/Frequency**
Caffeine	No / Yes	
Smoking	No / Yes	
Alcohol	No / Yes	
Marijuana	No / Yes	
Other Drugs?	No / Yes	

VII: Social History

1. How far did you go in school?

   _____

2. What is your current job/occupation?

   _____

3. Are you married? If so, for how long?

   _____

4. Do you have children? If so, how many?

   _____

5. What do you do in your free time to relax?

   _____

6. Do you have a religious affiliation?

   _____

7. Have you had any legal issues (arrests, charges, time in jail)? ☐ No ☐ Yes

   _____

8. Have you ever been the victim of physical abuse? ☐ No ☐ Yes
9. Have you ever been the victim of sexual abuse or rape? ☐ No ☐ Yes

VIII: Please briefly describe any concerns not otherwise addressed above. Please also briefly describe your treatment goals. (No need for much detail here, okay to just write a shorthand-list. We will discuss in greater depth during our appointments. Also ok to leave this section blank if preferred.)

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-
-
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Outpatient Psychiatric Clinic initial symptom review

What are the main things you are hoping to talk about today?

Are you experiencing of the following?

- ☐ Low mood
- ☐ Crying spells
- ☐ Feelings of worthlessness
- ☐ Feelings of hopelessness
- ☐ Thoughts of hurting yourself
- ☐ Thoughts of hurting others
- ☐ Thoughts of ending your life
- ☐ Lack of energy
- ☐ Sleeping too much
- ☐ Sleeping too little
- ☐ Frequent nightmares
- ☐ Too much energy
- ☐ Drinking too much alcohol
- ☐ Using drugs
- ☐ Feeling irritable
- ☐ Doing risky things
- ☐ Feeling on top of the world or very happy
- ☐ Feeling nervous
- ☐ Worrying too much
- ☐ Panic attacks
- ☐ Avoiding things that make you anxious
- ☐ Frequent unpleasant thoughts, urges, or images
- ☐ Needing to repeat certain behaviors or mental acts over and over again
- ☐ Difficulty concentrating
- ☐ Getting easily distracted
- ☐ Trouble with memory or forgetfulness
- ☐ Hallucinations
- ☐ Paranoia
- ☐ Distress about the way your body looks
- ☐ Concern about your weight
- ☐ Binge eating
- ☐ Making yourself vomit

How many hours of sleep are you currently getting per night?

PC-PTSD-5

Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic. For example:

- a serious accident or fire
- a physical or sexual assault or abuse
- an earthquake or flood
- a war
- seeing someone be killed or seriously injured
- having a loved one die through homicide or suicide

Have you ever experienced this kind of event?

YES NO

If no, screen total = 0. Please stop here.

If yes, please answer the questions below.

In the past month, have you…

1. had nightmares about the event(s) or thought about the event(s) when you did not want to?

YES NO

2. tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)?

YES NO

3. been constantly on guard, watchful, or easily startled?

YES NO

4. felt numb or detached from people, activities, or your surroundings?

YES NO

5. felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused?

YES NO

Affix Patient Label Here

Mood Disorder Questionnaire (MDQ)

Has there ever been a period of time when you were not your usual self and…

	YES	NO
…you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?		
…you were so irritable that you shouted at people or started fights or arguments?		
…you felt much more self-confident than usual?		
…you got much less sleep than usual?		
…you were more talkative or spoke much faster than usual?		
…thoughts raced through your head or you couldn't slow your mind down?		
..you were so easily distracted by things around you that you had trouble concentrating or staying on track?		
…you had more energy than usual?		
…you were much more active or did many more things than usual?		
…you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?		
…you were much more interested in sex than usual?		
…you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?		
…spending money got you or your family in trouble?		
If you checked YES to more than one of the above, have several of these ever happened during the same period of time?		
How much of a problem did any of these cause you – like being unable to work; having family, money or legal troubles; getting into arguments or fights? □ No Problem □ Minor Problem □ Moderate Problem □ Serious Problem		
Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?		
Has a health professional ever told you that you have manic –depressive illness or bipolar disorder?		