Changing Lanes Christian Wellness Ministries and Counseling Center
Adult Patient Questionnaire

Patient Name: _____Date: _____

Please read the following questions and answer to the best of your ability by placing a checkmark in the appropriate boxes or fill in the blank as directed. Your cooperation is appreciated.

Referred by: _____

Please state in your own words why you have come to _____ today:

_____
_____
_____
_____
_____
_____
_____

Please check ALL of the following symptoms or thoughts that apply to you **AT THIS TIME or during the past six months:**

Depressed mood
Diminished interests or pleasure
Sleep disturbance
Fatigue
Change in appetite
Hopelessness
Pleasure in few activities
Weight change
Agitation
Excessive worry
I feel like I am losing control.
Irritability
Poor Concentration
Tension
Feelings of panic
Socially withdrawn
Use of alcohol
Use of other drugs
Use of tobacco
Anxiety in social settings
Makes careless mistakes
Does not complete tasks
Difficulty organizing
Forgetful
Confusion
Disorientation
Compulsive checking / counting
Indecisiveness
People talk about me.
Some people want to hurt me.
I feel emotionally distant from others.
I hear voices or sounds others do not hear.
I see things others do not see.
I smell things others do not smell.
Racing thoughts
I do risky or dangerous things.
Little interest in sexual activity
Sexual problems
Gender concerns
I don't like my body.
Binge eating
Self induced vomiting
Laxative abuse
Excessive fasting
Intense fear of weight gain
Impulsive
I think about hurting myself.
I have tried to hurt myself.
Sometimes I wish I were dead.
I think about hurting someone else.
Exposed to a significant traumatic event
Recurrent distressing dreams

Psychiatric History:

I have received treatment for: Substance abuse □ Mental health issues □ Both □

The treatment occurred at:

□ Other private psychiatrist □ Mental Health Center
□ Hospital □ Other counseling service □ Other facility

Are you presently being treated? Yes □ No □ If yes, by whom? _____
_____

Medical History:

Your current weight _____ Height in inches _____

Name of your primary care doctor _____

Phone: _____ Date last seen: _____

Do you have a history of any medical problem? Yes □ No □ If so, what? _____
_____

Are you presently being treated for any medical problem? Yes □ No □ If so, what?
_____

_____

Past surgeries: _____

_____

_____

_____

Date of last Menses: _____

What form of birth control do you use? _____

Have you ever been treated for a nutritional problem?	□ Yes	□ No
Do you make yourself sick because you feel uncomfortably full?	□ Yes	□ No
Do you worry you have lost control over how much you eat?	□ Yes	□ No
Have you recently lost more than 14 pounds in a 3 month period?	□ Yes	□ No
Do you believe yourself to be fat when others say you are too thin?	□ Yes	□ No
Would you say that food dominates your life?	□ Yes	□ No

Are you experiencing any physical pain? Yes ___ No ___

Have you ever received treatment for any of the following medical conditions?

Neurological impairment	Asthma
Seizure disorder	Emphysema
Visual loss / impairment	Chronic bronchitis
Hearing loss / impairment	Tuberculosis / +PPD
Dementia	Cancer
GI disorder	Thyroid disease
Obesity	Diabetes
Significantly underweight	Pregnancy
Cirrhosis	Irregular menstrual periods
Hepatitis	Musculoskeletal condition
Heart condition	HIV / AIDS / Related condition
Hypertension	Other

Please list any medications you are presently prescribed.

_____
_____
_____
_____

Thank you for your cooperation and patience. Your therapist/physician will see you shortly and discuss these and other issues in greater detail and help you develop a treatment plan to effectively deal with these issues.