**POPE PAUL VI INSTITUTE PHYSICIANS, PC**

# CONFIDENTIAL PATIENT INFORMATION QUESTIONNAIRE

**KELLY A. MORROW, Ph.D.**

An important part of my work with you is to learn as much as possible about your current life and your history. This allows me to better understand the kinds of attitudes, experiences, and strengths that you bring with you. To allow me to provide the highest possible quality of service, I ask that you answer the following survey as completely and honestly as possible.

| Name: | Sex: M F | Birthdate: | Age: |
|---|---|---|---|

| Address: | City: | St: | ZIP: |
|---|---|---|---|

| Home Phone: _____<br>May we leave message? __ Yes __ No | Cell Phone: _____<br>May we leave message? __ Yes __ No | E-mail : _____<br>May we e-mail you? __ Yes __ No<br>***BE AWARE that e-mail may NOT be confidential!*** |
|---|---|---|

| Social Security #: | Years of Education: | Occupation: |
|---|---|---|

Health Insurance Company:

What is your current Religious Affiliation?

__ Catholic __ Protestant/Evangelical __Jewish __L.D.S. __Islamic __Other __No Affiliation

Marital Status: __Single __ Married (how long? _____) __ Separated (how long? _____)

__ Co-Habitating (how long? _____) __ Divorced (how long? _____) __ Widowed (how long? _____)

Are you currently Employed? __ Yes __ No If yes, __ FT __ PT

Current Employer/Position:

Please list work-related stressors, if any:

Names and Ages of all Household Members:

Were you referred to Dr. Morrow? __ Yes __ No If Yes, by whom?

What specific assistance would you like? (Why have you come today?)

Are you currently receiving counseling services/therapy from anyone? __ Yes __ No

If Yes, from whom?

Have you ever received mental health services in the past? __ Yes __ No

If Yes, Where and When (year)?

Have you ever had Psychological Testing? __ Yes __ No

If Yes, Where and When (year)?

Have you ever been previously prescribed psychiatric medication? __ Yes __ No

If Yes, Medication and Year:

**HEALTH AND SOCIAL INFORMATION**

How is your physical health at present? __ Poor __ Unsatisfactory __ Satisfactory __ Good __ Very Good

Please list any current or persistent physical symptoms or health concerns (e.g. chronic pain, headaches, infertility, diabetes, etc.):

Who is your Primary Care Physician?

| Height: | Weight: |
|---|---|

Present Weight: __ Satisfactory? __ Unsatisfactory? Compare to 1 year ago: __ Same? __ More? __ Less?

Please check any of the following behaviors that you have engaged in during the last three months.

| | |
|---|---|
| __ 1. Fasting to lose weight | __ 7. Overeating/binge eating |
| __ 2. Following low calorie diets | __ 8. Restricting carbohydrates/fats |
| __ 3. Vomiting after eating | __ 9. Feeling out of control while eating |
| __ 4. Using laxative/diet pills | __ 10. Feeling frightened of weight gain |
| __ 5. Exercising to lose weight | __ 11. Feeling unhappy about the inability to lose weight |
| __ 6. Using enemas for weight loss | |

At the present time, do you see yourself as:
__ Extremely Thin __ Somewhat Thin __ Normal Weight
__ Somewhat Overweight __ Extremely Overweight

What do you do for exercise? # Times/Week

Do you take time each day to relax and take it easy?

What are your Leisure Activities/Interests?

Do you have any difficulty with your sleep? __ Yes __No
If yes: __ Can't get to sleep __ Can't stay asleep __ Early Morning Awakening __ Sleep too much

How many hours do you sleep each day? Is this enough?

Energy Level: __ Sufficient for most of the things I want to do __ Tired most of the time

Diet: Are you on a special diet?

Average number of cups/glasses consumed daily: __ Coffee __ Tea __ Cola __ Energy Drinks

Average number of Alcoholic Drinks/Beers/Glasses of Wine per day? Week? Month?
__ Never Drink Quit in _____ (year) Why?

How often do you engage in recreational drug use? __ Daily __ Weekly __ Monthly __ Rarely __ Never

***Please list all currently Prescribed Medications:***

| **MEDICINE** | **THE REASON YOU ARE TAKING IT** |
|---|---|
| | |
| | |
| | |
| | |

Have you had suicidal thoughts recently? __ Frequently __ Sometimes __ Rarely __ Never When?

Have you had suicidal thoughts in the past? __ Frequently __ Sometimes __ Rarely __ Never When?

On a scale of 1-10, how would you rate the quality of your current relationship/marriage? (N/A if not is relationship)

In the last year, have you experienced any significant life changes or stressors? __ Yes __No *(Please list/describe)*

**FAMILY HISTORY**

| ***Please mark which Family Members, if any, have experienced the following problems:*** | | | | |
|---|---|---|---|---|
| | **Father** | **Mother** | **Sibling** | **Grandparents** |
| Depression | | | | |
| Bipolar Disorder | | | | |
| Anxiety Disorders | | | | |
| Panic Attacks | | | | |
| Schizophrenia | | | | |
| Alcohol/Substance Abuse | | | | |
| Eating Disrders | | | | |
| Obsessive-Compulsive Disorders | | | | |
| Trauma History | | | | |
| Suicide Attempts | | | | |

How satisfied are you with the quality of your sexual activity?

__ Not Satisfied At All __Somewhat Satisfied __ Satisfied __ Very Satisfied __ Extremely Satisfied

Have you ever had any form of sexual contact with which you were uncomfortable or did not want?
(Indicate the most serious event if there has been one.)

__ 1. No
__ 2. Possibly
__ 3. Yes, due to social pressure
__ 4. Yes, under the influence of alcohol or other drugs
__ 5. Yes, by threat of force
__ 6. Yes, by use of force or display of weapon

Is this something you may want to discuss at some point in Therapy? __ Yes __No

**CURRENT DIFFICULTIES**

| ***Below, check all that apply to you:*** | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Current** | **Past** | | **Current** | **Past** | | **Current** | **Past** | |
| | | Depressed Mood / Sad | | | Alcohol/Substance Abuse | | | Losing Temper Easily |
| | | Wild Mood Swings | | | Frequent Physical Complaints | | | Can't Enjoy Sex |
| | | Rapid Speech | | | Eating Disorder | | | Feeling Helpless |
| | | Anxiety | | | Body Image Problems | | | Wanting to Hurt Others |
| | | Panic Attacks | | | Homicidal Thoughts | | | Can't Concentrate |
| | | Phobias | | | Suicide Attempt | | | Crying A Llot |
| | | Fears About Sins | | | No Appetite | | | Rapid Heartbeat |
| | | Hallucinations | | | Headaches | | | Afraid of Failure |
| | | Unexplained Loss of Time | | | Nightmares | | | Feeling Hopeless |
| | | Unexplained Memory Lapses | | | Feeling Sad | | | Wanting to Run Away |
| | | Repetitive Thoughts (e.g. Obsessions) | | | Repetitive Behaviors (e.g. Frequent Checking, Hand Washing) | | | Wanting to Hurt Myself |

| ***How much do you agree with the following?*** | **Strongly Agree** | **Agree** | **Disagree** | **Strongly Disagree** |
|---|---|---|---|---|
| *I feel good about myself.* | ☐ | ☐ | ☐ | ☐ |
| *I can deal with my problems.* | ☐ | ☐ | ☐ | ☐ |
| *I can accomplish what I want.* | ☐ | ☐ | ☐ | ☐ |
| *I have friends and family who support me.* | ☐ | ☐ | ☐ | ☐ |

**PERSONAL RESOURCES**

| |
|---|
| **What do you like most about yourself?** |
| **What helps you cope?** |
| **What are your goals for therapy?** |
| **Is there anything else you want me to know about you or your situation?** |