FRONTLINE QUESTIONAIRE

Name: _____ Date of Birth: _____Date: _____

Your answer to these questions will allow a better understanding of your problems and how to help you. If the question does not apply to you, write N/A.

Identifying Data: Age: ____ Sex: _____ Marital Status: _____ Race/Ethnic Group: _____

Who is living in the home and how are they related to you?

Occupation: _____ # of hours worked per week: _____ Which shift: _____

Referred by: _____

Presenting Problem: What problem/problems prompted you to arrange this evaluation?

When did you first become aware of these problems/symptoms?

Have the problems been getting worse recently? _____ If so, starting when?

Have you ever had similar problems/symptoms in years past?

When?

How long did they last?

Did the problems/symptoms ever totally go away between now and then?

What kinds of stressful things are going on in your life lately?

Biggest:

2nd Biggest:

Review of symptoms:
Has there been any change in your sleep pattern? _____ Since When? _____

What time do you turn out the light to go to sleep?

How long does it take you to fall asleep?

Please circle of describe what interferes with falling to sleep:
Worries Muscles won□t relax Jumpy legs Just not tired Afraid to go to sleep

What time do you get up for the day?

How often do you wake up during the night?

What wakes you up?

Do you Snore loudly?_____ Ever wake up gasping for breath? _____

Has your **appetite** or **weight** changed, and how?

Has there been any change in your energy level? _____ Describe:

Are you having any Crying spells? _____ How often?

What kinds of hobbies and activities do you enjoy when you are feeling well?

Have you been doing these things lately? _____ If not, why not?

What percentage of the time do you feel one or more of the following unpleasant moods:

Sad? _____ Apathetic, blah, □don□t give a hoot about anything?□_____

Irritable, short-tempered, easily frustrated? _____ Nervous, worried, tense? _____

Have you had any **negative thoughts or feelings**? (circle those that are present)
Hopeless Helpless Worthless Guilty Empty inside

How long have you felt this way?

How often do suicidal thoughts cross your mind?

How old were you the first time you ever had any suicidal thoughts?

Have you ever tried to kill yourself?

Have you noticed any **difference in your mood or energy** in spring/summer compared to fall/winter? Please describe?

Are you having any **problems with your thinking**, such as your (please circle and describe)
Concentration Ability to think clearly Memory

If so, how long have these been problems for you?

Have you had any problems recently with **constipation or diarrhea**?

Do you have any painful conditions?

Where does it hurt?

How long has the pain been going on?

On a scale of 0 □10, with zero representing no pain and 10 representing the worst possible pain, what is your pain level most days?

Have you ever had times when □out of the blue□you have felt scared to death, or as if you are losing your mind? _____ How often? _____

Has this feeling ever been accompanied by any of the following? (please circle)

Shortness of breath Chest Pain Heart racing Dizziness Sweating

Nausea Numbness Headache Discomfort around people

Fear of leaving home or your □safety zone□? Fear of feeling this way again?

Have you ever been troubled by nightmares or intrusive memories or traumatic things that really did happen in the past? _____

How often?

Please state briefly what happened:

How much time do you spend worrying every day?

What kinds of things do you worry about?

How long have you been a worrier?

Have you ever felt the need to do any quirky or repetitive things? _____

Circle any that are, or have been present

Counting things for no reason Checking locks, alarms, the stove, etc. Picking at scabs

Obsessive cleanliness Excessive hand-washing/bathing Plucking hair Making lists

Needing things to be perfect, symmetrical, or evenly spaced Saving useless items/being a packrat

Other (please describe): _____

How much time per day have you spent engaged in such activities: _____

Have you ever been troubled by any intrusive, □icky□thoughts, that pop into your head and that you can□t shake out of your mind? _____ *Please describe*:

Have you ever had any worrisome eating or weight loss behavior? _____
Circle those that apply:

Making you self throw up Going without food for extended periods of time

Diet pills Laxatives Binge eating Excessive exercising

When was the last time you did any of these things? _____

Is there a specific object or situation that you are or have been afraid of? *(such as crossing bridges, being in an elevator, snakes, spiders, etc.)* _____ *Please describe:*

Do you ever worry so much about your appearance that it interferes with work or socializing? _____
Please describe:

Do you ever worry so much about how you will be perceived by other people that you avoid certain situations? _____ *Please describe:*

Do you blush easily or often? _____

As a child, did you have significant problems with *(circle those that apply):*

Being sad Being nervous/worried Being extremely shy Learning Keeping friends

Concentrating Listening up to the teacher Getting in trouble A bad temper

Getting organized Getting bored easily Fidgeting/squirming Being hyper/restless

Settling down to go to sleep Grades Paying attention Reading Being a chatterbox

Being called □lazy□ feeling dumb

How old were you when you had these problems: *Please describe:*

Which of these continue to be problems for you? *(draw a box around those that still apply)*

Have you ever had any of your senses play a trick on you? *(such as hearing a voice calling your name, or yelling at you, or telling you that you are bad, or to hurt yourself or others, or seeing things that other people in the room didn't see, distorted images, strange tastes or smells or peculiar sensations in your body)*_____ *Please describe what and when:*

Have you ever had any frightening thoughts, or unusual beliefs, or ideas or behaviors that seemed odd or out-of-touch with reality? *(such as thinking the TV or radio announcer was speaking just to you or that someone was out to do you*

harm when that was not really the case, or that you had any special powers or gifts, or that you are cursed: _____
Please describe what and when:

MOOD DISORDER QUESTIONAIRE

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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 and found you didn□t really miss it?		
□ you were much more talkative or spoke much faster than usual?		
□ thoughts raced through your head or you couldn□t slow down your mind?		
□ you were so easily distracted by things around you that you had trouble concentrating or staying on track		
□ you had much 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 into trouble?		
If you checked YES to more than one of the above, have several of these ever happened at the same 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: *Please circle one response only.* *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? If yes, who?		
Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?		
Does your mood ever change so rapidly that it's like somebody "flipped a switch"? (This question is a Shrinklady addition)		
Please describe any YES answers:		

If you answered "YES" to have had racing thoughts on the Mood Disorder Questionnaire, please circle the words that describe the nature of those racing thoughts.

Worries circling inside your head like a hamster on a wheel Still make sense

Jumbled Confused No logical connecting thread Noisy mind that won't shut off

PSYCHIATRIC HISTORY:

Have you ever been hospitalized for treatment of mental health or substance abuse problems? _____

How many times? _____

Where: When? Name of Doctor:

Have you ever taken any medication to treat mental health or substance abuse problems? _____

Please list:

Name of medication	Dr who prescribed	Approx. treatment dates	Response and/or side effects

For **women**, did you become depressed during the year following the birth of any of your children? _____

Have you ever had counseling or talk therapy?

Who did you see?

Approximate dates?

What did you talk about?

Was it helpful?

Have you ever tried to kill yourself? _____ How many times? _____

How old were you? What did you do? What was going on in you life at the time? Were drugs/alcohol involved?

Have you ever deliberately inflicted harm or pain on yourself? _____ If so, how?

What purpose did it serve?

When was the last time you injured yourself?

PAST MEDICAL HISTORY:

Please list *all* of your current physicians, where they work, and what they are treating you for:

Name of Doctor/primary care provider:	Address/location:	What he/she is treating you for:

How long since your last physical examination: _____ Blood tests: _____

Please list any significant health problems or surgeries you have had, and when:

For women, how old where you when you started having periods? _____

Do you think you might be pregnant? _____

Are you on any form of birth control? _____

Do you notice any worsening of mood/anxiety in the week of so prior to your period? _____

Circle any of the following problems you have had and mark and "X" through items that have NOT been a problem for you:

High blood pressure	Hearth disease	Lung disease/Asthma	Glaucoma	
Headaches Cancer	Blood sugar too high or too low		Head injury	Seizures
Gastrointestinal problems	Arthritis	kidney disease	Liver disease	Thyroid Disease
Male/Female problems	Infertility	Hot flashes	Unintended pregnancy	
Please Describe:				

Please list all of the **prescription** and **non-prescription** medication, supplements and herbal remedies you have taken over the past few months.

Currently taking:	Took recently, but have stopped:	Prescribe by whom?

Are you allergic to any medications: *Please list:*

FAMILY HISTORY:
Please list any significant medical illnesses among blood relatives. Who had what illness?
Specifically any thyroid disease or sleep disorders?

Please list any psychiatric illness you feel may have existed among blood relatives, *whether evaluated and treated or not.* (Anxiety, panic attacks, depression, mood swings, erratic behavior, ADHD, schizophrenia, etc.) Who had what illness?

Have any blood relatives struggled with drug or alcohol problems? _____ Who had what?

SOCIAL HISTORY:
Have you ever been married? _____ Please list your age at time of marriage(s) and at end of marriage(s), and the reason marriage(s) ended:

Please list your children, where they live, and how often you see them:

How many grandchildren do you have? _____ How often do you see them?

How much schooling do have you had?

Did you have any Special Education classes?

What sorts of jobs have you held and for how long?

Have you ever been on Worker's Comp or any other sort of disability income? _____

What kind: _____

Are there any disability claims/application pending now? _____

Please list any legal difficulties you have had in your lifetime, and your age at the time?

Has there been a time in your life when you have over-relied on alcohol? _____

When was that?

What purpose did the alcohol serve for you?

How many alcoholic beverages do you drink in the average month?_____

When was your last drink?

Please list any recreational drugs you have used, when, and why you used them?

When was the last time you used any □street□drugs?

How has your use of drugs or alcohol presented problems in your school, work, family, or social life and/or with the law?

Please circle any of the following that you have experienced.

How old were you? Who was involved?

Physical abuse Emotional abuse Sexual abuse Witness of violence

Do you skip meals? _____ How often and which ones?

How many and what kind of caffeinated beverages do you drink every day?

Do you smoke? _____ How much? _____ When did you start? _____

THANK YOU FOR YOUR TIME AND PATIENCE IN COMPLETING THIS QUESTIONNAIRE.
Please present it to the receptionist for the doctor to review prior to you appointment.

For clinic use only
MSE:

DIAGNOSTIC IMPRESSION:

Axis I: Primary Diagnosis AND comorbid conditions, including substance abuse issues, ADHD:

Axis II: Personality traits/styles, learning disabilities, IQ issues:

Axis III: Non-psychiatric medical problems:

Axis V: Global Assessment of functioning (GAF) scale [Mark the appropriate level with an X]

100	90	80	70	60	50	40	30	20	10	0
Exceptional functioning	*Good Functioning*	*Transient Stress-Related Symptoms*	*Mild Symptoms OK Overall functions*	*Moderate Symptoms In one area*	*Serious Problems in several areas*	*Major Impairment in several areas*	*Inability to function in almost all areas*	*Some danger to self or others*	*Persistent danger to self or others*	*Insuff info to assess*

TREATMENT PLAN:

1. Order pertinent labs. (Circle labs ordered and write in any additional testing)

   CBC with Diff, comprehensive metabolic panel, lipid panel, TSH, UA, urine drug screen

2. Have patient read □Helping Yourself Feel Better□for information of managing stress.

3. Suggest appropriate books/websites for patient and family to read.

4. Instructions regarding alcohol, caffeine, diet, relaxation training.

5. Referral for psychotherapy (where appropriate), Name of therapist/agency. _____

6. Multivitamin with extra B complex daily.

7. For women, calcium with vitamin D 600 mg twice daily. (unless specifically advised not to supplement)

8. Psychotropic medication(s) prescribed: (including printed instructions and □Regarding Medications□ sheet)
   ☐Informed consent discussion held ☐Off-label use discussion held

9. Return visit in _____weeks.

Patient name: _____ DOB: _____ Date of evaluation: _____