

UAB Depression Clinic New Patient Information Form

	Sleeping too late
	Napping too much during the day
	Eating less than normal
	Weight loss (except when trying to lose weight)
	Eating more than normal
	Weight gain (except when trying to gain weight)
	Difficulty concentrating
	Memory problems
	Anxious or nervous
	Feelings of guilt (like you've done something wrong)
	Feeling worthless (like you don't have any value)
	Feeling hopeless (like things will never improve)
	Irritability (check here if very severe and hard to control: <input type="checkbox"/>)
	Angry outbursts (like yelling or throwing things)
	Trouble with self-care (such as dressing or bathing)
	Avoiding social situations
	Panic or anxiety attacks
	Being anxious about social situations (such as speaking in public)
	Racing thoughts
	Talking more than usual
	Increased activity (such as writing, cleaning, or exercising more)
	Risky behavior
	Increased sexual feelings or behavior
	Increased spending
	Being manic
	Obsessive thoughts
	Compulsive behaviors (counting, washing hands, cleaning)
	Thoughts about something bad that happened to you
	Having nightmare (How often: <input type="checkbox"/> Almost every night <input type="checkbox"/> Frequent <input type="checkbox"/> Occasionally)
	Hearing voices or other sounds that others can't
	Seeing that's other people can't see
	Being afraid someone is/was going to hurt you (feeling paranoid)
	Reading other people's thoughts
	Feeling that your thoughts are being read
	Feeling like the television or radio is talking to you specifically
	Eating very little in order to lose weight
	Exercising to lose weight
	Using laxatives to lose weight
	Using other methods to lose weight
	Binge eating
	Eating without feeling hungry
	Eating very little or restricting what you eat

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Are there any things that you are so afraid of that you try to avoid them completely? _____

Abuse

Were you abused in any way as a child or teenager? Yes No

If yes, please describe: _____

Were you abused in any way as an adult? Yes No

If yes, please describe: _____

Trauma

Have you ever experienced or witnessed a serious traumatic event? Traumatic events may include exposure to war, threatened or actual physical or sexual violence, natural or human-made disasters, or serious accidents. Yes No

If yes, please describe: _____

Prior medications

Please list any medications you have taken to treat mental or emotional problems:

Name of medication	Maximum dose you took (mg.)	About how long did you take it? (Circle days, weeks, months, or years)		How much did it help? (Circle 1= very little, 2=moderate amount, 3= a lot)			Was there a side effect problem with it? (Circle Yes or No)	
		Days Mon	Wks Yrs	1	2	3	Yes	No
		Days Mon	Wks Yrs	1	2	3	Yes	No
		Days Mon	Wks Yrs	1	2	3	Yes	No
		Days Mon	Wks Yrs	1	2	3	Yes	No
		Days Mon	Wks Yrs	1	2	3	Yes	No
		Days Mon	Wks Yrs	1	2	3	Yes	No
		Days Mon	Wks Yrs	1	2	3	Yes	No
		Days Mon	Wks Yrs	1	2	3	Yes	No
		Days Mon	Wks Yrs	1	2	3	Yes	No
		Days Mon	Wks Yrs	1	2	3	Yes	No
		Days Mon	Wks Yrs	1	2	3	Yes	No
		Days Mon	Wks Yrs	1	2	3	Yes	No

Have you ever seen a therapist or counselor? Yes No. If yes, please list names: _____

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Have you had any of the following treatments? (Check all that apply)

Type of treatment	Check if yes	Did it help? (Circle Yes or No)	When?	Where?	No _____	_____
Electroconvulsive therapy (ECT)		Yes No				
Transcranial Magnetic Stimulation (TMS)		Yes No				
Vagal Nerve Stimulations (VNS)		Yes No				
Deep Brain Stimulation (DBS)		Yes No				
Transcranial Direct Current Stimulation (TDCS)		Yes No				
Ketamine		Yes No				
EMDR		Yes No				

Please list any other treatments you have received for mental or emotional problems: _____

Past Medical History

For the following medical conditions, please indicate whether this is a current or post problem.

Medical Condition	Current	Past
Acid reflux		
Anemia or other blood disorder		
Asthma		
Cancer (list types:		
Chronic obstructive pulmonary disease (COPD)		
Chronic pain (list where):		
Diabetes		
Eye problems (list type):		
Fainting		
Heart disease		
Hepatitis		
High blood pressure		
High cholesterol or triglycerides		
HIV/AIDS		
Seizures		

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Do you have any other allergies? Yes No If yes, please list here: _____

Are you currently having any other health problems? Yes No. If yes, please list here: _____

Alcohol

Do you use alcohol? Yes No If yes, how many days per week do you drink? _____
 On those days, how many drinks? _____ Do you have a history of alcohol problems? Yes No.
 If yes, is that: Current Past

Drugs

Have you used street drugs of any kind in the last year? Yes No. If yes, what drug(s)? _____

 Have you had problems with prescription or street drugs? Yes No. If yes, is that: Current Past
 If yes, what drug(s)? _____

Family History

Please check if anyone in your family has been affected by the following conditions:

	Mother	Father	Sibling	Children	Aunts/Uncles /Cousins	Grandparents	Other (write in)
ADD/ADHD							
Alcohol Abuse or Dependence							
Anxiety/Anxiety Disorder							
Autism/Developmental Disorder							
Bipolar Disorder/Manic Depressive Disorder							
Cancer							
Dementia/Alzheimer's Disease							
Depression							
Drug Abuse or Dependence							
Heart Disease							
High blood pressure							
Obsessive-Compulsive Disorder							
Panic attacks							
Parkinson's Disease							
Schizophrenia/Psychosis							
Stroke							

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Substance Abuse							
Suicide Attempts							
Thyroid Problems							

Please list any other conditions in your family: _____

Social History

Where were you born (city, state, country)? _____

Where were you raised (city, state, country) same as above) _____

Relationship and marital status (check all that apply): Are you: Married Committed relationship Living together Divorced
 Separated Widowed Single Other: _____

With whom do you live with? Spouse Girl/boyfriend Parents Alone Other: _____

How far did you go in school? _____ Years Graduated high school Part college Graduated college
 Part graduate or professional school Completed graduate or professional school

If college graduate, terminal degree: BS/BA MA Ph.D. M.D. J.D. DDS Other: _____

Employment status: Full-time Part-time Unemployed Student Disabled

If disabled, reason for disability: _____

What is or was your main occupation? _____

Do you have any children? Yes No

How many: Daughters: _____ Ages: _____ Sons: _____ Ages: _____

Do you have adopted children? Yes No Do you have foster children? Yes No

Were you adopted? Yes No Do you have a twin? Yes No

As a child were you: A foster child? Yes No Removed from the family home? Yes No

Religion/spirituality: Christian Judaism Buddhist Muslim Hindu Agnostic Atheist
 None Other: _____ Are you active in your faith? Yes No

Have you had prior legal problems? Yes No Current? Yes No Type: _____

What is your main sources of stress now? _____

Is there anything else you'd like to share? _____

THE MOOD DISORDER QUESTIONNAIRE

Instructions: Please answer each question to the best of your ability.

1. 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?	Yes	No
...you were so irritable that you shouted at people or started fights or arguments?	Yes	No
...you felt much more self-confident than usual?	Yes	No
...you got much less sleep than usual and found you didn't really miss it?	Yes	No
...you were much more talkative or spoke much faster than usual?	Yes	No
...thoughts raced through your head or you couldn't slow your mind down?	Yes	No
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	Yes	No
...you had much more energy than usual?	Yes	No
...you were much more active or did many more things than usual?	Yes	No
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	Yes	No
...you were much more interested in sex than usual?	Yes	No
...you did things that were unusual for you or other people might have thought were excessive, foolish, or risky?	Yes	No
...spending money got you or your family into trouble?	Yes	No
To how many of the items above did you answer "yes"?		
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	Yes	No
3. 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? <i>Please circle only one response:</i>		
No Problem Minor Problem Moderate Problem Serious Problem		
	Yes	No
4. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	Yes	No
5. Has a health professional ever told you that you have manic-depressive illness?	Yes	No

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 Patient Health Questionnaire – 9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?

(Use "X" to indicate your answer)		Not at all	Several days	More than half the days	Every day
1.	Little interest or pleasure in doing things	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
2.	Feeling down, depressed, or hopeless	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
3.	Trouble falling or staying asleep, or sleeping too much	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
4.	Feeling tired or having little energy	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
5.	Poor appetite or overeating	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
6.	Feeling bad about yourself – or that you are a failure or have let yourself or your family down	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
7.	Trouble concentrating on things, such as reading the newspaper or watching television	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
8.	Moving or speaking so slowly that other people could have noticed? Or the opposite –being so fidgety or restless that you have been moving around a lot more than usual	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3
9.	Thoughts that you would be better off dead or of hurting yourself in some way	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3

Please add up your score and write it here: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Thank you!

Once you have completed this form please fax, or scan and email it.

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