

# Greatland Clinical Associates



1400 W. Benson, Suite 525 Anchorage, Alaska 99503

## Pre-Evaluation Questionnaire

*To better help us serve you, please provide us with the following information prior to your evaluation with your clinician. All information is confidential and will be part of your clinical record. If you need more space feel free to use the back of the paper. Please feel free to ask us questions about any of the information requested. Thank you. (Attention: **Parents** completing form, provide child's information)*

**Date:** \_\_\_\_\_

**Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Gender:** M / F

**Marital Status:**  Single  Married  Separated  Divorced  Other: \_\_\_\_\_

**Please describe the main reason for your visit/current concerns:** *including behaviors, thoughts, and feelings*

**In what situations, at what time or day(s), in what place(s) does this occur?**

**How often do you feel this way or have this problem?**

**Rate the intensity of the problem on a scale of 1-10:** 1 2 3 4 5 6 7 8 9 10  
less intense more intense

**Medical Information**

*Please be as specific as possible*

**Do you have any drug allergies?**  Yes  No *If yes please list all drugs and the reactions they cause:*

**Are you currently taking any medications?**  Yes  No *If yes, please list all medications, dosages, times taken per day, and how long you have been taking them. (also include supplements (ie vitamins, herbs, etc.)*

**Do you have any currently active medical illnesses?**  Yes  No *If yes, please list them:*

**Do you have a history of any other medical illnesses?**  Yes  No *If yes, please list them:*

**Have you had any surgeries?**  Yes  No *If yes, please list the procedures, approximate dates, and any problems or complications:*

**Obstetrical/Gynecological history:**  *Not applicable*

Number or pregnancies: \_\_\_\_\_

Number of children: \_\_\_\_\_

Date of my last menstrual period: \_\_\_\_\_

Was it normal?:  Yes  No *If no, please explain:*

**Who is your Primary Care Physician?** \_\_\_\_\_

**Do you have a pharmacy that you prefer?**  Yes  No \_\_\_\_\_

**When was your last check-up?** \_\_\_\_\_

**Medical Information Continued**

**When was the last time you had any blood-work done?** \_\_\_\_\_

**Have you ever been knocked out or diagnosed with a concussion?**  Yes  No *If yes, please explain:*

**Have you ever had a seizure or undergone an EEG?**  Yes  No *If yes, please explain:*

**Have you ever had any neuro-imaging:** (ie brain CT scan or MRI?)  Yes  No *If yes, please explain:*

**What was your birth-weight?**  Can't recall \_\_\_\_\_

**Are you aware of any pre-natal exposures:** (*did your Mother drink or use any other substances while she was pregnant with you?*)  Yes  No  Not sure *If yes, please explain:*

**Are you aware of any problems with your own pregnancy?** (*when your mother was pregnant with you, during or shortly after delivery?*)  Yes  No  Not sure *If yes, please explain:*

**Were you ever formally diagnosed with any developmental delays – learning to talk (and requiring a speech therapist), or to walk, or motor coordination?**  Yes  No *If yes, please explain:*

**Tell us about your *biological* family history:** (*this will help us understand what health issues may be of concern to you*)

**Do you have any biologically related relatives with a history of the following?**

Depression?  Yes  No *If yes, who:*

Bipolar or manic-depressive illness?  Yes  No *If yes, who:*

Schizophrenia?  Yes  No *If yes, who:*

Anxiety disorders such as Panic, Post-traumatic stress disorder, or OCD?  Yes  No *If yes, who:*

Eating disorders such as Anorexia Nervosa, Bulimia, or Binge Eating disorder?  Yes  No *If yes, who:*

Addiction?  Yes  No *If yes, whom, what:*

- Alcohol
- Marijuana
- Cocaine
- Amphetamines
- IV drugs
- Prescription drugs
- Other drugs/substances: \_\_\_\_\_

General medical illnesses?  Yes  No *If yes, whom, what:*

**Have you ever seen a psychiatrist?**  Yes  No *If yes, who, where, and when:*

**Have you ever seen a counselor or therapist?**  Yes  No *If yes, who, where, and when*

**Have you ever been diagnosed with a mental health condition?**  Yes  No *If yes, please explain what diagnosis, when, and by whom:*

**Have you ever been on psychiatric medications?**  Yes  No *If yes, please list names, doses, and approximate dates:*

**Have you ever been hospitalized for psychiatric reasons before?**  Yes  No *If yes, please list location and dates:*

**Have you ever attempted or seriously considered suicide?**  Yes  No *If yes, when:*

**Are you currently considering suicide?**  Yes  No

**Do you have a plan?**  Yes  No

### Current or Historical Substance Use

**Do you currently use, or do you have a history of using in the past?** *Please check those that apply*

- Tobacco/Chew/Nicotine gum or patch
- Caffeine/ *How Much* \_\_\_\_\_
- Alcohol
- Marijuana
- Cocaine
- IV drugs
- Inhalants
- Prescription drugs
- Heroin
- Amphetamines (include methamphetamine)
- Hallucinogens
- Illicit prescription drugs (ie oxycontin)
- Other drugs/substances: \_\_\_\_\_

**If you have a history or are currently using alcohol or other substances please answer the following questions:**  Not Applicable

Have you ever experienced withdrawal symptoms from alcohol or other drugs?  Yes  No

Has anyone ever told you that they thought you had a problem with drugs or alcohol?  Yes  No

Have you ever felt guilty about your drug or alcohol use?  Yes  No

Have you ever felt annoyed when someone talked to you about your drug or alcohol use?  Yes  No

Have you used drugs or alcohol first thing in the morning?  Yes  No

## Social History

**Where were you born and raised?**

**Do you have any siblings?** *How many, gender, ages?*

**Tell us about your educational history.** *Currently in school, grades, difficulties, diploma, GED, degree(s) attained?*

**Tell us about your work history?** *(types of jobs have you held, where, what is your current employment status, military)*

**Do you have any current legal involvement and/or history of legal involvement?**  Yes  No  
*If yes, please describe*

**Have you ever been convicted of a crime (assault, DWI, theft)?**  Yes  No  
*If yes, please describe (don't include parking or minor traffic tickets)*

**Have you experienced any significant traumas in your life?**  Yes  No  
*If yes, please describe*

**Have you felt unsafe or at risk of violence in any of your relationships?**  Yes  No  
*If yes, please describe*

**Is there any other relevant information which you would like to be sure we discuss during our interview time?** *Please provide additional information?*