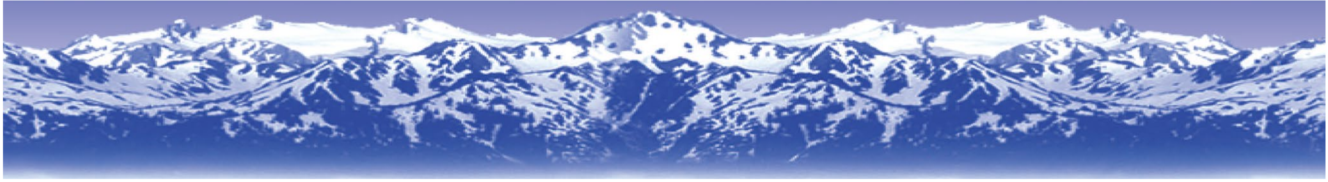
GREATLAND CLINICAL ASSOCIATES



1400 W. Benson Blvd., Suite 315, Anchorage, AK 99503
Phone: **(907) 929-4009** Fax: **(907) 929-4902**

Pre-Evaluation Questionnaire

To better help us serve you, please provide us with the following information prior to your evaluation appointment. 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 packet. If you have any questions about the information requested, we will gladly assist you.

Date: ____________________

Patient's Legal Name: ____ **DOB:** ______________________

Preferred Name: ____

Gender: Male / Female / Non-binary / Other ____________ **Pronouns:** He / She / They / *Other*: ________

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Other: ________________________________

Employment Status: ☐ Employed ☐ Unemployed ☐ Searching ☐ Disability ☐ Other: ______________________

Mental Health

Please describe your main reasons for seeking mental healthcare: *(i.e., struggles, current concerns, including behaviors, thoughts, feelings, etc.)*

In what situations do these problems tend to occur? *(i.e., places, activities, days, etc. that you have noticed increase the likelihood of causing or exasperating your symptoms)*

How often do these feelings or problems arise?

Rate the *intensity* of these feelings or problems, on a scale of 1-10: **1 2 3 4 5 6 7 8 9 10**
less intense — more intense

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 professionally assessed and diagnosed with a mental health condition? ☐ Yes ☐ No *If yes, please list when, by whom, and what diagnosis/ diagnoses:*

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

Have you ever been hospitalized for psychiatric reasons before? ☐ Yes ☐ No *If yes, please list location(s) 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

Medical Information

(Please be as specific as possible)

Who is your Primary Care Physician? ______________________________

When was your last check-up? ______________________________

When was the last time you had any blood-work done? ______________________________

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

Are you currently taking <u>any</u> medications? ☐ Yes ☐ No *If* yes, *please list all medications, dosages, times taken per day, and how long you have been taking them* (t*his includes vitamins, supplements, and herbs, etc.)*:

Do you have a pharmacy that you prefer? ☐ Yes ☐ No ______________________________

Do you currently have any 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 last menstrual period: ___________________ Was it normal? ☐ Yes ☐ No *If no, please explain:*

Have you ever been knocked out or diagnosed with a concussion or traumatic brain injury? ☐ 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: (i.e., brain CT scan or MRI?) ☐ Yes ☐ No *If yes, please explain:*

Developmental History

What was your birth-weight? ☐ Cannot recall ____

Are you aware of any pre-natal exposures while you were in utero? (i.e., *did your mother drink alcohol 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 birth? ☐ Yes ☐ No ☐ Not sure *If yes, please explain:*

Were you ever formally diagnosed with any developmental delays? (i.e., *learning to talk (and requiring a speech therapist), to walk, problems with ear, nose, throat, or motor coordination*? ☐ Yes ☐ No *If yes, please explain:*

Current or Historical Substance Use

Do you or have you ever used any of the substances below? *Please check those that apply:*

- ☐ Tobacco/Chew/Nicotine gum, vape, or patch
- ☐ Caffeine/ *How Much* _______________
- ☐ Alcohol
- ☐ Marijuana- flower, dabs, or vape pen
- ☐ Cocaine
- ☐ IV drugs
- ☐ Inhalants
- ☐ Prescription drugs
- ☐ Heroin
- ☐ Amphetamines (i.e. methamphetamine)
- ☐ Hallucinogens
- ☐ Illicit prescription drugs (i.e., Oxycontin)
- ☐ Other drugs/substances:

____

____

____

If you use or have a history of using any of the substances above, 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

Biological Family History

(This will help us understand what health issues may be of concern to you or that you may be predisposed to)

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

Depression? ☐ Yes ☐ No

Bipolar or Manic-Depressive Illness? ☐ Yes ☐ No

Schizophrenia? ☐ Yes ☐ No

Anxiety disorders such as Panic, Post-Traumatic Stress Disorder, or OCD? ☐ Yes ☐ No

Eating disorders such as Anorexia Nervosa, Bulimia, or Binge Eating disorder? ☐ Yes ☐ No

Do any of your biological family members have other major, general medical illnesses? ☐ Yes ☐ No

If yes, whom, what:

Do any of your biological relatives have a history of addiction? ☐ Yes ☐ No *If 'yes,' please use the boxes below to indicate which substance(s) your family members are/ were addicted to:*

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

____

____

____

Social History

Where were you born and raised?

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

Have you ever been removed from your home or been in foster care?

Tell us about your educational history: (i.e., *currently in school, grades, difficulties, diploma, GED, degree(s) attained, etc.*)

Tell us about your work history? (i.e., *type of jobs you have held, where, what is your current employment status, military, etc.*)

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:*
(note: please exclude parking or minor traffic tickets)

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

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

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

We recognize that answering some of the questions in this packet may be difficult, but we appreciate your honesty. This information will make a big difference in your clinician's ability to provide proper care for you.

Updated 10/24/2023

Thank you!

- Greatland Clinical Associates