PALOUSE PSYCHIATRY & BEHAVIORAL HEALTH

PULLMAN REGIONAL HOSPITAL CLINIC NETWORK

Welcome to our clinic!

Attached are the registration documents that we will need for you to complete and bring with you to your appointment.

It is required that you show up 15 minutes early for your appointment. If paperwork is not completed, or you are unable to arrive early, your appointment may need to be rescheduled.

Our office is located in the Corporate Point Building (on the 2nd floor), across the street from Pullman Regional Hospital and next to Zeppoz.

Thank you and we look forward to seeing you.
Psychiatry & Behavioral Health
840 SE Bishop Blvd., #203
Pullman, WA 99163
509-339-2394 (Phone)
509-336-7484 (Fax)

PALOUSE PSYCHIATRY & BEHAVIORAL HEALTH
PULLMAN REGIONAL HOSPITAL CLINIC NETWORK

HEALTH HISTORY

Primary Care Physician: ______________________ Primary Care Physician Phone #: __________________

Who referred you to us? ________________________ Date of Last Complete Check-Up: ________________

What are the primary concerns you are wanting to address?_____ ______________________________________

____

____

Are you currently taking any medication? ☐ No ☐ Yes

Please list all medications, including herbal supplements/over the counter drugs:

Name of Medication:	Dose:	Purpose:	Effect:	Prescribing Provider:

MEDICAL HISTORY

Have you ever experienced serious illness, injury, or hospitalization, or do you have any physical disabilities?
☐ No ☐ Yes Describe: ____

____

____

Have you experienced any of the following?
☐ Head injuries Describe: ____
☐ Seizures Describe: ____
☐ Abnormal motor twitches Describe: ____

Have you had any difficulties with:
Eating? ☐ No ☐ Yes – Describe: ____
Speaking? ☐ No ☐ Yes– Describe: ____
Menstruating? ☐ No ☐ Yes– Describe: ____

Current Substance Use

☐ Alcohol: _____ drinks, _______ times per week.
☐ Tobacco: (cigarettes, chewing tobacco, vaporizer), _____ (amount) daily, for _____ years.
☐ Caffeine: _____ cups per day, _____ times per week.
☐ Other Substance use:

PATIENT/FAMILY HISTORY

	Patient	Family Member(s)
Adverse Reaction to Anesthesia		
Allergies (dust, pollen, pets, foods)		
Anemia		
Asthma		
Atherosclerosis		
Autoimmune Disorder		
Cancer of the Breast		
Colon Cancer		
Congenital Anomaly		
Coronary Artery Disease		
Dementia		
Diabetes		
Eczema		
Genetic Disorder		
Glaucoma		
Heart Attack		
High Blood Pressure		
Huntington's Disease		
Hyperlipidemia		
Kidney Disease		
Lung Cancer		
Malignant Hyperthermia		
Migraines		
Mild Cognitive Impairment (MCI)		
Multiple Sclerosis		
Obesity		
Osteoporosis		
Other Blood Disorder		
Other Cancer		
Ovarian Cancer		
Parkinson's Disease		
Prostate Cancer		
Rheumatoid Arthritis		
Seizures		
Skin Cancer		
Strokes		
Thyroid Disease		
Tobacco Abuse		
Tuberculosis		

KEY

M: Mother F: Father
S: Sister B: Brother
Son: Son Dau: Daughter
PGF: Paternal Grandfather
PGM: Paternal Grandmother
MGF: Maternal Grandfather
MGM: Maternal Grandmother
A: Aunt U: Uncle C: Cousin

Any other health conditions not listed?

____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____

Sleep

Have you had any difficulties with sleeping? ☐ No ☐ Yes – Describe:

____

Do you experience problems falling asleep? ☐ No ☐ Yes – Describe: ______________________________

____

Do you experience problems staying asleep? ☐ No ☐ Yes – Describe: ______________________________

____

Any history of parasomnias (e.g. sleepwalking, night terrors, etc.)? ☐ No ☐ Yes – Describe: ______________

____

Have you ever completed a sleep study? ☐ No ☐ Yes – Describe: ______________________________

____

Do you nap? ☐ No ☐ Yes – Describe: ______________________________________

Sleep / Wake Schedule: ____

Average hours of sleep per night: ______________________________________

Number of hours that would be ideal: ____________________________________

Suicide Risk Assessment

Have you ever had feelings or thoughts that you didn't want to live? ☐ No ☐ Yes

➔ *If YES, please answer the following. If NO, please skip to the next section.*

Do you currently feel that you don't want to live? ☐ Yes ☐ No

How often do you have these thoughts? ____________________

When was the last time you had thoughts of dying? ____________________

Has anything happened recently to make you feel this way? ____________________

____

On a scale of 1 to 10 (10 being strongest), how strong is your desire to kill yourself currently? _____

Would anything make it better? ____________________

Have you ever thought about how you would kill yourself? ____________________

Is the method you would use readily available? ____________________

Have you planned a time for this? ____________________

Is there anything that would stop you from killing yourself? ____________________

Do you feel hopeless and/or worthless? ____________________

Have you ever tried to kill or harm yourself before? ____________________

On a scale from 0 to 100 (100 being full confidence), how confident are you that you will be able to keep yourself safe currently? ________

Have you ever received a mental health diagnosis or treatment previously? ☐ No ☐ Yes

If yes, where? ____

____

Have you ever completed a psychiatric inpatient stay? ☐ No ☐ Yes

If yes, please describe: ____

____

____

Is there any other relevant information you would like to provide us? ☐ No ☐ Yes

If yes, please describe: ____

____

PSYCHIATRIC HISTORY

Current Symptoms Checklist: (check once for any symptoms present, circle for major symptoms)

- ☐ Depressed mood
- ☐ Unable to enjoy activities
- ☐ Sleep pattern disturbance
- ☐ Loss of interest
- ☐ Concentration/forgetfulness
- ☐ Change in appetite
- ☐ Excessive guilt
- ☐ Fatigue
- ☐ Decreased libido
- ☐ Racing thoughts
- ☐ Impulsivity
- ☐ Increased risky behavior
- ☐ Increased libido
- ☐ Decreased need for sleep
- ☐ Excessive energy
- ☐ Increased irritability
- ☐ Crying spells
- ☐ Indecisiveness
- ☐ Excessive worry
- ☐ Panic attacks
- ☐ Avoidance
- ☐ Hallucinations
- ☐ Suspiciousness
- ☐ Dissociation
- ☐ ____________
- ☐ ____________
- ☐ ____________

PATIENT/FAMILY PSYCHIATRIC HISTORY

	Patient	Family Member(s)
Anxiety		
Attention Deficit /Hyperactivity Disorder		
Autism Spectrum Disorder		
Bipolar Disorder		
Depression		
Hoarding Disorder		
Intellectual Disability		
Learning Difficulties/SLD		
Obsessive-Compulsive Disorder		
Personality Disorder		
Post-Traumatic Stress Disorder		
Schizophrenia		
Suicidal Behavior/Ideation		
Violent Behavior/Ideation		
Other:		

KEY

M: Mother F: Father
S: Sister B: Brother
Son: Son Dau: Daughter
PGF: Paternal Grandfather
PGM: Paternal Grandmother
MGF: Maternal Grandfather
MGM: Maternal Grandmother
A: Aunt U: Uncle C: Cousin

If anyone has been diagnosed with any of the above mental health disorders, please list the diagnosis and whether or not treatment has been received, including medication:

Diagnosis:	Treatment Received:	Medications:

DEVELOPMENTAL HISTORY

Were alcohol, drugs or tobacco used during your mother's pregnancy? ☐ No ☐ Yes (If yes, see below.)

a. Which substance(s)? ____________________
b. Quantity and frequency? ____________________
c. How long/Still currently using? ____________________

Did your mother experience any high stress levels or illness during pregnancy? ☐ No ☐ Yes
(If yes, please describe the illness and any treatment, medication or special diet your mother received.)____________

____

Where were you born? ____________________
Were you born prematurely? ☐ No ☐ Yes If yes, number of weeks: __________
How long did labor last? ____________________ Birth Weight: ____________________

How were you born? ☐ Head first ☐ Feet first ☐ Breech (buttocks first) ☐ C-Section ☐ Other____________

Were there any difficulties or peculiarities in your appearance or behavior at birth or during infancy?
☐ No ☐ Yes If yes, describe: ____________________

Were you given oxygen? ☐ No ☐ Yes -If yes, for how long? ____________________
Blood transfusions? ☐ No ☐ Yes
Placed in an incubator? ☐ No ☐ Yes -If yes, for how long? ____________________
Other medical treatment? ☐ No ☐ Yes - Describe: ____________________

INFANCY & NEWBORN

By whom were you raised? ____________________
Looking back on your early childhood years, and based on what you have been told by others, were you: (Check any that apply.)

- ☐ Difficult to Sooth
- ☐ Easy-Going
- ☐ Slow to Warm

Please describe: ____________________

____

Did you experience any developmental delays or problems? ☐ No ☐ Yes

Describe: ____________________

____

____

At what age did you first smile? ______________ Walk alone? ______________
Say your first word? ______________ Speak in sentences? ______________
At what age was bowel training complete? ______________ Urinary training? ______________
Was there any difficulty in training? ☐ No ☐ Yes - Describe: ______________
Any past or present problems in bowel or urinary control? ☐ No ☐ Yes - Describe: ______________

____

EARLY CHILDHOOD

Did you experience any difficulties with expressing your emotions in childhood? ☐ No ☐ Yes
Describe: ______________________________

Did it take a long time for you to warm up to new situations or new people? ☐ No ☐ Yes
Describe: ______________________________

Did you react *strongly/not at all* to physical pain? ☐ No ☐ Yes
(circle one, if applicable)
Describe: ______________________________

Did you react strongly to other things? ☐ No ☐ Yes Explain: ______________________________

EARLY SOCIALIZATION:

Describe your early socialization skills with others within and outside the home: ______________________________

____

____

What parenting strategy/style was implemented at home (i.e. Time-Out, Positive Reinforcement, etc.)
Describe: ______________________________

____

____

EDUCATIONAL AND CULTURAL HISTORY

What is your primary language?: ______________________________

What is your cultural or ethnic background?: ______________________________

What is the highest grade you completed in school?: ______________________________

- ➔ What was your GPA when you graduated from high school?: ______________

Have you completed any additional degrees (e.g. A.A., B.S., Master's, PhD, MD, etc.)? ☐ No ☐ Yes
If yes, please describe: ______________________________

____

- ➔ What was your GPA in college?: ______________
- ➔ What was your GPA in graduate school?: ______________

Any history of disciplinary action in school?: ☐ No ☐ Yes
If yes, please describe: ______________________________

____

____

CURRENT SOCIAL HISTORY

List all individuals currently living with you. Specify relationship (e.g. spouse, friend, sibling [full, half, step, foster], other)

First & Last Name	Sex	Age	School Grade / Occupation	Relationship to Patient

Any significant life transitions within the home or environment? ☐ No ☐ Yes
If yes, please describe: ____________________

Are you currently involved in any litigation? ☐ No ☐ Yes
If yes, please describe: ____________________

Do any of the following problems apply to your current living situation?

Marital or relationship problems	☐ No ☐ Yes
Problems with other persons living at home	☐ No ☐ Yes
Problems with present living situation/housing	☐ No ☐ Yes
Recent major changes or stressors in the living situation or family	☐ No ☐ Yes
Violence in the home or neighborhood	☐ No ☐ Yes
Alcohol or drug problems in the home or neighborhood	☐ No ☐ Yes
Other problems, such as legal issues, financial strain, etc.	☐ No ☐ Yes

If yes to any of the above, please describe:

____

____

Please describe your typical day:

____

____

What sorts of hobbies do you enjoy? ____________________

Are there any other factors in your current social/living situation that you would like to discuss?

____

____

____

ASRS Symptom Checklist

Name:	Date:

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.	Never	Rarely	Sometimes	Often	Very Often
Part A					
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?					
3. How often do you have problems remembering appointments or obligations?					
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?					
Part B					
7. How often do you make careless mistakes when you have to work on a boring or difficult project?					
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
10. How often do you misplace or have difficulty finding things at home or at work?					
11. How often are you distracted by activity or noise around you?					
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?					
13. How often do you feel restless or fidgety?					
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?					
15. How often do you find yourself talking too much when you are in social situations?					
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?					
17. How often do you have difficulty waiting your turn in situations when turn taking is required?					
18. How often do you interrupt others when they are busy?					

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: ______________________ DATE: ____________

Over the last *2 weeks*, how often have you been bothered by any of the following problems? *(use "✓" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns		+	+
(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).	TOTAL:			

10. 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 ________

Copyright © 1999 Pfizer Inc. All rights reserved. Reproduced with permission. PRIME-MD© is a trademark of Pfizer Inc.

A2663B 10-04-2005

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these 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 __________

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.