Steven E. Locke, MD

10 Deer Run, Wayland, MA 01778

(508) 343-0001 Phone | (508) 213-3776 Fax

steven.locke@drstevenlocke.com | www.drstevenlocke.com

QUESTIONNAIRE FOR NEW PATIENTS

Please complete this questionnaire and mail it or bring the completed questionnaire with you when you come for your appointment. If you need additional space, please use the back of the page. **All of the information you provide on this questionnaire will be treated with complete confidentiality**. Please do not email this form.

Today's date _____

Your Name _____

DOB _____ Age _____

Home Ph _____ Work Ph _____

Cell Ph _____ Email _____

Street Address _____

City _____ State _____ ZIP _____

Primary Care Physician _____

Street Address _____

City _____ State _____ ZIP _____

Phone _____

Who referred you to me? _____

I. Please state the reason you are seeking consultation.

What is the problem (or problems) you would like help with?

When and how did the problem(s) begin?

What have you done so far to try to alleviate the problem(s)?

II. Substance Use

Do you smoke cigarettes? ..... ☐ Yes ☐ No
IF YES, how many cigarettes daily? _____ For how many years? _____
Are you frequently exposed to second-hand smoke at work or at home? ..... ☐ Yes ☐ No
Do you drink caffeinated beverages (coffee, tea, or caffeinated soft drinks)? ..... ☐ Yes ☐ No
IF YES, how many caffeinated drinks per day? _____
Do you drink alcohol? ..... ☐ Yes ☐ No
IF YES, how many drinks per week? _____
Have you or anyone close to you ever thought that you had a drinking problem? ..... ☐ Yes ☐ No
Have you ever felt you ought to cut down on your drinking? ..... ☐ Yes ☐ No
Have people ever annoyed you by criticizing your drinking? ..... ☐ Yes ☐ No
Have you ever felt bad or guilty about your drinking? ..... ☐ Yes ☐ No
Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover ? ..... ☐ Yes ☐ No
Have you used "recreational" drugs (marijuana, cocaine, speed, hallucinogens)? ..... ☐ Yes ☐ No
IF YES, which drugs?

Have you or anyone close to you ever thought that you had a drug problem? ..... ☐ Yes ☐ No
Have you ever abused or misused prescription drugs? ..... ☐ Yes ☐ No
IF YES, provide details:

III. Psychiatric Treatment History

Have you ever been hospitalized for psychiatric treatment? ☐ Yes ☐ No
IF YES, please specify:
Dates of hospitalization: from _____ to _____ .
Name of hospital: _____
Reason for hospitalization: _____
Was the hospital treatment helpful? ☐ Yes ☐ No
Dates of hospitalization: from _____ to _____ .
Name of hospital: _____
Reason for hospitalization: _____
Was the hospital treatment helpful? ☐ Yes ☐ No

Are you currently seeing a psychiatrist? ☐ Yes ☐ No

IF YES, please specify:

Name of psychiatrist: _____ Seeing since _____

What town is s/he in? _____ Telephone number _____

Has this treatment been helpful? ☐ Yes ☐ No

Are you currently seeing a therapist or counselor? ☐ Yes ☐ No

IF YES, please specify:

Name of therapist: _____ Seeing since _____

What town is therapist in? _____ Telephone number _____

Has this therapy been helpful? ☐ Yes ☐ No

Are you **currently** taking any medication for treatment of psychiatric or emotional problems?

☐ Yes ☐ No

IF YES, please specify:

Name of medication	Dose and frequency	Taken when? (dates)	Benefits and/or side effects

Have you seen other psychiatrists, therapists or counselors in the past? ☐ Yes ☐ No

IF YES, please specify:

	Dates of Treatment		**Was treatment helpful?**		
Name of Clinician	From	To	Yes	No	Not sure
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐

Have you taken medications **in the past** for treatment of psychiatric or emotional problems?

☐ Yes ☐ No. IF YES, please specify:

Name of medication	Dose and frequency	Taken when? (dates)	Benefits and/or side effects

IV. Medical History

Overall, would you say your physical health is:

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

Have you suffered from any of the following medical problems? (check all that apply)

- ☐ allergic reactions to medications
- ☐ high blood pressure
- ☐ food allergies
- ☐ hepatitis
- ☐ environmental allergies
- ☐ chronic pain
- ☐ asthma
- ☐ HIV/AIDS
- ☐ Cancer
- ☐ cataract
- ☐ diabetes
- ☐ glaucoma
- ☐ head injuries
- ☐ severe or recurrent headaches
- ☐ hearing impairment
- ☐ heart disease
- ☐ loss of consciousness
- ☐ recurrent gastrointestinal illness (nausea, vomiting, constipation, or diarrhea)
- ☐ hospitalization for medical illness in the last 5 years
- ☐ other medical problems (describe)hormonal problems
- ☐ kidney problems
- ☐ liver problems
- ☐ prostate problems
- ☐ seizures
- ☐ stroke
- ☐ surgery
- ☐ sexually-transmitted disease
- ☐ thyroid condition
- ☐ ulcers

IF YES to any of above, please provide details:

Have you noticed any of the following symptoms or problems **in the last six months**?

(Please check all that apply)

- ☐ fevers
- ☐ fatigue
- ☐ weight loss
- ☐ changes in your vision
- ☐ double vision
- ☐ eye pain or irritation
- ☐ hearing loss
- ☐ ringing in your ears
- ☐ ear pain
- ☐ sore throat
- ☐ nose bleeds
- ☐ runny nose
- ☐ sores in your mouth
- ☐ shortness of breath
- ☐ persistent cough
- ☐ wheezing
- ☐ chest pain
- ☐ rapid heart beat or palpitations
- ☐ swelling of legs or ankles
- ☐ nausea or vomiting
- ☐ diarrhea
- ☐ constipation
- ☐ abdominal pain
- ☐ blood in your urine
- ☐ painful urination
- ☐ difficulty passing urine
- ☐ sexual problems
- ☐ decreased interest in sex
- ☐ joint pain or swelling
- ☐ aches or pains in your arms or legs
- ☐ back pain
- ☐ breast swelling, masses, or discharge
- ☐ skin rashes or sores
- ☐ headaches
- ☐ dizziness, light-headedness, or vertigo
- ☐ numbness or tingling
- ☐ tremors
- ☐ problems with balance or coordination
- ☐ changes in menses
- ☐ hair loss
- ☐
- ☐
- ☐
- ☐
- ☐
- ☐
- ☐
- ☐
- ☐

IF YES to any of above, please provide details:

Are you concerned about the quality of your sleep? ..... ☐ Yes ☐ No

IF YES:

Trouble falling asleep? ..... ☐ Yes ☐ No

Frequent waking during the night? ..... ☐ Yes ☐ No

Wake up early in the morning and can't fall back to sleep? ..... ☐ Yes ☐ No

Don't feel rested in the morning? ..... ☐ Yes ☐ No

On average, how many hours of sleep do you get each night? _____

Do you frequently feel fatigued, exhausted, or sleepy during the day?..... ☐ Yes ☐ No

Has your weight changed significantly in the last year? ☐ Yes ☐ No

IF YES Weight gain? How much _____ lbs. Weight loss? How much _____ lbs.

Date of your last physical examination: _____ By whom: _____

Were laboratory or imaging studies done? (IF YES, please obtain and provide the results or reports.)

Are you currently taking any medication other than the psychiatric medications listed above (include prescription medications, birth control pills, and over-the-counter medicines, such as cold or allergy preparations)?

☐ Yes ☐ No IF YES, please specify below. Use additional page if needed.

Name of medication	Dose and frequency	Taken when? (dates)	Why taking this medication?

Are you currently sexually active? ☐ Yes ☐ No

How would you describe your sexual orientation?

☐ Heterosexual ☐Gay/Lesbian ☐ Bisexual

Females Only

IF you are sexually active with a man, are you using any form of birth control? ☐ Yes ☐ No

IF YES, what form of birth control do you use?

Date of your last gynecological examination _____

Do you have any problems related to your menstrual periods, such as irregular periods, prolonged or especially painful periods, or excessive bleeding? ☐ Yes ☐ No

IF YES, please describe:

Do your symptoms (anxiety, depression, other psychiatric symptoms) vary according to any pattern during the course of your menstrual cycle? For example, do you become more depressed, anxious, or irritable before your period? ☐ Yes ☐ No

IF YES, please describe:

Have you ever been pregnant? ☐ Yes ☐ No

IF YES, please specify:	Number	How old were you?
Live births		
Miscarriages		
Abortions		

Have you ever had a serious depression after the birth of a child? ☐ Yes ☐ No

Are you currently trying to become pregnant or do you plan to try to become pregnant in the near future? ☐ Yes ☐ No

Are you currently breast-feeding? ☐ Yes ☐ No

Have you gone through the menopause? ☐ Yes ☐ No. IF YES, at what age? _____

Males only

If you are sexually active, do you use a condom? ☐ Yes ☐ No

Do you have any problems with sexual function (erections, ejaculation)? ☐ Yes ☐ No

V. Personal History

Family Background

	First Name	Current age or age at death	If not living, your age when he or she died	Occupation	☑ if living with you	If alive and **not** living with you, where does he or she live now?
Spouse					☐	
Children					☐	
					☐	
					☐	
					☐	
Father					☐	
Mother					☐	
Brothers & Sisters					☐	
					☐	
					☐	
					☐	
					☐	

Others living in your household

Name	Relationship to you	Age

Marital status

☐	Married	How long	☐ Separated	How long
☐	Life partner	How long	☐ Separated	How long
☐	Divorced	How long	☐ Widowed	How long
☐	Never married			

Have you been married previously? ☐ Yes ☐ No. IF YES, please list dates of previous marriages:

If you are currently married or living with a partner, are you now or have you in the past experienced significant conflicts in your relationship? ☐ Yes ☐ No

IF YES, please describe:

Family stressors

Do any family/household members currently suffer from significant physical health problems?

☐ Yes ☐ No. IF YES, please describe:

Do any family/household members currently suffer from significant mental/emotional health problems?

☐ Yes ☐ No. IF YES, please describe:

Are there any other significant stresses currently affecting your family life (e.g., financial concerns, health problems, extended family concerns or conflicts, job problems, etc.)?

☐ Yes ☐ No. IF YES, please describe:

Safety

Have you ever been exposed to violence in your living situation (as a child or as an adult)?

☐ Yes ☐ No. IF YES, please describe:

Do you feel safe in your current living situation?

☐ Yes ☐ No. IF NO, please describe:

Do you have access to firearms?

☐ Yes ☐ No. IF YES, please describe:

Do you use the following personal safety equipment:

- ☐ seatbelts
- ☐ bicycle helmet
- ☐ ski helmet
- ☐ nonslip surface or mat in bathtub
- ☐ working smoke detectors in home
- ☐ eye and/or ear protection

Education

Your educational attainment (check highest level obtained):

- ☐ 8th grade or less
- ☐ some high school
- ☐ high school graduate or equivalency (GED)
- ☐ some college or associate degree
- ☐ college graduate
- ☐ advanced college degree

Occupation

Your occupation _____

Work hours per week (approximate): _____

How many vacation days do you take per year? _____

When was your most recent vacation? _____

How long have you been in your current position? _____

How satisfied are you with your work or job?

☐ Very satisfied ☐ Satisfied ☐ Dissatisfied ☐ Very dissatisfied

Religion

When you were a child, what was your parents' religion?

Father _____ Mother _____

What is your religion? _____

How important are your religious or spiritual beliefs to you:

☐ Very important ☐ Important ☐ Somewhat important ☐ Unimportant

Is there someone in your life whom you can turn to for help or support? ☐ Yes ☐ No

If YES: how satisfied are you with the support available to you?

☐ Very satisfied ☐ Satisfied ☐ Dissatisfied ☐ Very dissatisfied

VI. Family History:

Have any of your biological relatives had ANY of the following problems?

	Father	Mother	Siblings	Your children	Other family
Depression					
Anxiety or nervousness					
Panic attacks or panic disorder					
Phobias (claustrophobia, fear of flying, etc.)					
OCD (obsessive-compulsive disorder)					
Alcohol abuse					
Drug abuse					
Schizophrenia					
Bipolar disorder (manic depressive)					
Obsessive-compulsive disorder					
Learning difficulties or ADHD as child					
Mental retardation					
Hospitalized for psychiatric problem					
Other psychiatric problem					
Suicide					
Violence					
Dementia (or Alzheimer's disease)					
Cancer					
Diabetes					
Heart disease					
Stroke					
Neurological disease (e.g., multiple sclerosis)					
Thyroid Disease					
Other familial medical illnesses					
Unknown					

VII. Recent stress

Please indicate with a ✔ the following:

In the last MONTH…	Never	Almost never	Sometimes	Fairly often	Very often
How often have you felt that you were unable to control the important things in your life?					
How often have you felt confident about your ability to handle your personal problems?					
How often have you felt that things were going your way?					
How often have you felt difficulties were piling up so high that you could not overcome them?					

VIII. Please indicate how much your problems have been interfering with your daily life.

Circle one number **above each line**.

1. Because of my problems, my **WORK** is impaired:

0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Not at all	Mildly		Moderately			Markedly		Very Severely (cannot work)		

2. Because of my problems, my **SOCIAL LIFE / LEISURE** is impaired:

0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Not at all	Mildly		Moderately			Markedly		Very Severely (No social life)		

3. Because of my problems, my **FAMILY LIFE AND ABILITY TO CARRY OUT HOME RESPONSIBILITIES** are impaired

0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Not at all	Mildly		Moderately			Markedly			Very Severely	

IX. Patient Health Questionnaire (PHQ)

1. During the last **4 weeks**, how much have you been bothered by any of the following problems? **(Use ✓ to indicate your answer)**

Problem	Not bothered (0)	Bothered a little (1)	Bothered a lot (2)	
Stomach pain				
Back pain				
Pain in your arms, legs, or joints (knees, hips, etc.)				
Menstrual cramps or other problems with your periods				
Pain or problems during sexual intercourse				
Headaches				
Chest pain				
Dizziness				
Fainting spells				
Feeling your heart pound or race				
Shortness of breath				
Constipation, loose bowels, or diarrhea				
Nausea, gas, or indigestion				
PLEASE ADD UP YOUR SCORE				

2. Over the last **2 weeks**, how often have you been bothered by any of the following problems? **(Use ✓ to indicate your answer)**

Problem	Not at all (0)	Some of the days (1)	More than half the days (2)	Nearly every day (3)	
Little interest or pleasure in doing things					
Feeling down, depressed, or hopeless					
Trouble falling or staying asleep, or sleeping too much					
Feeling tired or having little energy					
Poor appetite or overeating					
Feeling bad about yourself — or that you are a failure or have let yourself or your family down					
Trouble concentrating on things, such as reading the newspaper or watching television					
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					
Thoughts that you would be better off dead or of hurting yourself in some way					
PLEASE ADD UP YOUR SCORE					

3. Questions about anxiety

a. In the **last 4 weeks**, have you had an anxiety attack – suddenly feeling fear or panic? ☐ Yes ☐ No
(If you checked "NO", go to question #5.)

b. Has this ever happened before? ☐ Yes ☐ No

c. Do some of these attacks come suddenly out of the blue –– that is, in situations where you don't expect to be nervous or uncomfortable? ☐ Yes ☐ No

d. Do these attacks bother you a lot or are you worried about having another attack?
☐ Yes ☐ No

4. Think about your last bad anxiety attack.

a. Were you short of breath? ..... ☐ Yes ☐ No

b. Did your heart race, pound, or skip? ..... ☐ Yes ☐ No

c. Did you have chest pain or pressure? ..... ☐ Yes ☐ No

d. Did you sweat? ..... ☐ Yes ☐ No

e. Did you feel as if you were choking? ..... ☐ Yes ☐ No

f. Did you have hot flashes or chills? ..... ☐ Yes ☐ No

g. Did you have nausea or an upset stomach, or the feeling that you were going to have diarrhea? ..... ☐ Yes ☐ No

h. Did you feel dizzy, unsteady, or faint? ..... ☐ Yes ☐ No

i. Did you have tingling or numbness in parts of your body? ..... ☐ Yes ☐ No

j. Did you tremble or shake? ..... ☐ Yes ☐ No

k. Were you afraid you were dying? ..... ☐ Yes ☐ No

5. Over the **last 2 weeks**, how often have you been bothered by the following problems? **(Use ✓ to indicate your answer)**

Problem	Not at all (0)	Some of the days (1)	More than half the days (2)	Nearly every day (3)	
Feeling nervous, anxious or on edge					
Not being able to stop or control worrying					
Worrying too much about different things					
Trouble relaxing					
Being so restless that it is hard to sit still					
Becoming easily annoyed or irritable					
Feeling afraid as if something awful might happen					
PLEASE ADD UP YOUR SCORE					

6. Questions about eating:

a. Do you often feel that you can't control what or how much you eat? ..... ☐ Yes ☐ No

b. Do you often eat, within any 2-hour period, what most people would regard as an unusually large amount of food? ..... ☐ Yes ☐ No

c. Has this been as often as twice a week for the last 3 months? ..... ☐ Yes ☐ No

7. In the last 3 months have you often done any of the following in order to avoid gaining weight?

a. Made yourself vomit? ..... ☐ Yes ☐ No

b. Used laxatives to try to lose weight? ..... ☐ Yes ☐ No

c. Fasted—not eaten anything at all for at least 24 hours? ..... ☐ Yes ☐ No

d. Exercised for more than an hour specifically to avoid gaining weight after binge eating? ..... ☐ Yes ☐ No

e. Have you ever tried to lose weight because you thought you were fat even when others thought you were too thin? ..... ☐ Yes ☐ No

X. Have you served in the US Armed Forces

☐ Yes ☐ No

IF YES, what type of discharge?

XI. Other

Is there anything else that you think I should know about you?

Thank you for the time and effort it took to complete this questionnaire.

How much time did it take you to complete this questionnaire? _____ minutes

How useful do you think providing this information in this manner will be in your care?

☐ Very useful ☐ Useful ☐ Somewhat useful ☐ Not useful