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Specializing in integrative mental health care of elite Texas athletes

New Patient Health Questionnaire

***Please complete and, if possible, fax or mail to Dr. Silvertooth prior to your first appointment so that she may review in advance.**

Name:	**DOB:**	**Address:**	**Primary phone number:**	**Secondary phone number:**
Email address:	**Referred by:**	**Preferred pharmacy and phone number:**	**Marital/relationship status:**	**Occupation:**
Social Security number:	**Sex/Gender:**			

Please describe the reason for the evaluation:

Prioritize Your Health Concerns:	**Date of Onset**	**Frequency and Severity**
1.		
2.		
3.		
4.		
5.		

What are your goals for treatment?

Current physician(s), therapist(s), and/or provider(s) and phone numbers (if available):

Current Symptoms (check all that apply):	☐ Hair loss	☐ Ringing in the ears
☐ Face numbness/weakness	☐ Blurred vision/double vision	☐ Hearing loss
☐ Jaw pain	☐ Tongue numbness/pain	☐ Problems chewing or swallowing
☐ Headache	☐ Neck/throat pain	☐ Cough
☐ Shortness of breath	☐ Chest pain/heart burn	☐ Fever
☐ Wheezing	☐ Breast pain or discharge	☐ Palpitations
☐ Joint pain (where?)	☐ Rash	☐ Numbness or tingling
☐ Weakness	☐ Fatigue	☐ Abdominal pain
☐ Nausea/vomiting	☐ Constipation	☐ Diarrhea
☐ Blood in the stool	☐ Bloating/abdominal swelling	☐ Pelvic pain
☐ Vaginal discharge	☐ Abnormal vaginal bleeding	☐ Problems with balance or falls
☐ Easy bruising	☐ Insomnia	☐ Excessive sleeping/falling asleep inappropriately
☐ Leg swelling	☐ Leg cramping when walking	☐ Unexplained weight loss

Past Medical History (Please check all that apply and describe):		
☐ Headaches	☐ Stroke	☐ Multiple sclerosis
☐ Parkinson's disease	☐ Dementia	☐ Hearing loss
☐ Concussion/brain injury	☐ Bell's palsy	☐ Trigeminal neuralgia
☐ Brain tumor	☐ Cervical spine/disk disease	☐ Seasonal allergies
☐ Thyroid disease	☐ Parathyroid disease	☐ Asthma
☐ COPD/emphysema	☐ Bronchitis	☐ Heart disease
☐ Lung cancer	☐ Breast cancer	☐ Aortic aneurysm
☐ Peptic ulcer disease	☐ Gastritis	☐ Reflux
☐ Gastrointestinal bleed	☐ Stomach/colon cancer	☐ Crohn's disease/ulcerative colitis
☐ Irritable bowel disease	☐ Liver disease/hepatitis	☐ Pancreatic cancer
☐ Pancreatitis	☐ Gallstones	☐ Diabetes
☐ High cholesterol/lipids	☐ High blood pressure	☐ Interstitial cystitis
☐ Kidney or bladder infections/disease	☐ Pelvic inflammatory disease	☐ Prostate disease
☐ Kidney stones	☐ Ovarian cysts/disease	☐ Ovarian cancer
☐ Genital problems	☐ Impotence/sexual dysfunction	☐ Rheumatoid arthritis
☐ Lupus	☐ Osteoarthritis	☐ Osteopenia/osteoarthritis
☐ Psoriasis/psoriatic arthritis	☐ Ankylosing spondylitis	☐ Tendonitis/tendon injury
☐ Fracture(s)	☐ Plantar fasciitis	☐ Muscle disease
☐ Anemia (kind?)	☐ HIV	☐ Dermatitis/rash
☐ Blood clots	☐ Other:	☐

Past Psychiatric History (please check all that apply and briefly describe):		
☐ Depression	☐ Bipolar/manic-depression	☐ Anxiety/panic attacks
☐ PTSD/major trauma	☐ Schizophrenia	☐ ADHD/learning disabilities
☐ Borderline personality disorder	☐ Social anxiety	☐ Other phobias
☐ OCD	☐ Skin picking disorder/trichotillomania	☐ Alcohol/substance abuse/dependence
☐ Autism spectrum/Asperger's	☐ Eating disorder	☐ Other:

Past Psychiatric Hospitalizations (Places and dates):	Self harm history:
Past Psychiatric Treatment: ☐ Psychotherapy ☐ Medications ☐ ECT ☐ rTMS ☐ EMDR ☐ Other:	Past psychiatric medication trials and outcomes (effects, side effects):

Surgeries (dates):

Menstrual History: Age of first menses: Date of last menstrual cycle: Please describe regularity and severity of menses: Are you on birth control medication or hormones? If yes, what?
Pregnancy History: Number of pregnancies: Age when pregnant: Any lost pregnancies? Describe any fertility difficulties:

Current Medications and dosages:

Current Supplements/Vitamins:

Medication Allergies:

Health Maintenance (results and dates if known):		
☐ Cholesterol/lipid levels	☐ Last tetanus/pertussis vaccine	☐ Mammogram
☐ HIV test	☐ Last flu shot	☐ Pap/pelvic exam
☐ PSA (men)	☐ Pneumonia vaccine	☐ Bone density test
☐ Other routine blood work:	☐ Shingles vaccine	☐ Prostate exam
		☐ Colonoscopy

Family Medical and Psychiatric History (list relation and age of onset, if known):		
☐ Depression	☐ Bipolar disorder	☐ Schizophrenia
☐ Dementia	☐ Substance abuse	☐ Anxiety
☐ Suicide attempt:	☐ Heart disease	☐ Diabetes
☐ Cancer	☐ Thyroid disease	☐ Joint disease
☐ Stroke	☐ Aneurysm	☐ Other

Substance Use History:	If current, amount/day:	Last use:
☐ Alcohol		
☐ Marijuana		
☐ Cocaine		
☐ Opiates/heroin		
☐ Methamphetamine/stimulant abuse		
☐ Sedative abuse (Xanax, etc)		
☐ **Cigarettes**		
☐ **Caffeine**		

Diet and Nutrition:
Please describe your daily diet and nutrition:

Do you have any dietary restrictions?

Do you have any food sensitivities, allergies or intolerances?

Do you have any concerns about your diet or nutrition? Please describe.

Do you have any concerns about your weight? Please describe.

Exercise and Physical Activity:
Please describe any routine physical activity, including frequency, intensity, duration and type.

Please describe any physical limitations that interfere with exercise:

Spirituality/Religion/Meditation:
Do you have a preferred religion or spiritual belief or routine meditative practice? Please describe.

Alternative/Complementary/Integrative Treatments Tried (please describe):		
☐ Acupuncture/acupressure	☐ Massage	☐ Craniosacral therapy
☐ Chiropractic	☐ Ayurvedic medicine	☐ Chinese medicine
☐ Yoga/tai chi/qigong	☐ Mindfulness/meditation/guided imagery	☐ Aromatherapy
☐ Homeopathy	☐ Naturopathy	☐ Herbal medicine
☐ Breath work	☐ Other:	

Sleep Health:

Do you have difficulties with your sleep? Please describe.

How many hours do you sleep on average each night?

Do you feel rested when you awake in the morning?

Do you have a strategy or routine for sleep?

Do you take any supplements or medications to help with sleep?