Elliot Behavioral Health Services

445 Cypress Street, Manchester NH 03103
(p) 603-668-4079 (f) 603-663-8349

Adult New Patient Information

Date today:	Date of birth:
Name:	
Reason for seeking treatment:	

Psychiatric history:

Prior diagnoses (if applicable):
Previous psychiatrist, psychologist or therapist Or Mental Health Center (if applicable):
Current therapist name and contact info (if applicable):

Have you ever been in the hospital for a mental health reason?	Yes	No
Have you ever had ECT (electroconvulsive therapy)?	Yes	No
Have you ever had TMS (transcranial magnetic stimulation)?	Yes	No
Have you ever had neuropsychological testing?	Yes	No

Have you ever taken any of the following medications? Please check all that apply

□ Prozac (fluoxetine)	□ Lithium	□ Abilify (aripiprazole)
□ Paxil (paroxetine)	□ Topamax (topiramate)	□ Zyprexa (olanzapine)
□ Zoloft (sertraline)	□ Neurontin (gabapentin)	□ Risperdal (risperidone)
□ Celexa (citalopram)	□ Depakote (divalproex)	□ Seroquel (quetiapine)
□ Lexapro (escitalopram)	□ Trileptal (Oxcarbazepine)	□ Geodon (ziprasidone)
□Trintellix (vortioxetine)	□ Tegtretol (carbamazepine)	□ Latuda (lurasidone)
□ Luvox (fluvoxamine)	□ Lamictal (lamotrigine)	□ Rexulti (brexpiprazole)
□ Remeron (mirtazapine)	□ Adderall (amphetamine-	□ Invega (paliperidone)
□ Effexor (venlafaxine)	dextroapmhetamine)	□ Clozaril (clozapine)
□ Cymbalta (duloxetine)	□ Vyvanse (lisdexamphetamine)	□ Vraylar (cariprazine)
□ Pristiq (desvenlafaxine)	□ Ritalin/Concerta/Metadate/	□ Saphris (asenapine)
□ Viibryd (vilazodone)	Daytrana/Quillivant/Jornay	□ Haldol (haloperidol)
□ Wellbutrin (bupropion)	(methylphenidate)	□ Thorazine (chlorpromazine)
□ Pamelor (nortriptyline)	□ Focalin/aztarys	□ Xanax (alprazolam)
□ Elavil (amitriptyline)	(dexmethylphenidate)	□ Valium (diazepam)
□ Anafranil (clomipramine)	□ Intuniv (guanfacine)	□ Klonopin (clonazepam)
□ BuSpar (buspirone)	□ Strattera (atomoxetine)	□ Ativan (lorazepam)
□ Sinequan (doxepin)	□ Qelbree (viloxazine)	□ Spravato (esketamine)
□ Desryel (trazodone)	□ Catapres (clonidine)	□ Revia/Vivitrol (naltrexone)
	□ Minipress (prazosin)	□ Other _____

Family History: Please mark an x in the box if applicable

Adopted?			Yes	No
	Siblings	Biological mother	Biological father	Other
Heart problems or unexplained death before 30 years old				
Depression				
Bipolar Disorder				
Anxiety Problems				
Obsessive Compulsive Disorder				
Schizophrenia				
PTSD				
Attention Problems				
Alcohol or Drug Problems				
Suicide attempts				

Social history:

Occupation			
Marital status	□Single □Life partner □Widowed □Divorced □ Married (# of years ____) Previous marriages? Yes No		
Current household members	Name	Age	Relationship
Highest level of education	□Less than high school □High school □College □Graduate Ever held back or special education or services? Yes No		
Military or law enforcement	Yes No		
Access to firearms	Yes No If yes: □ Firearms are stored unloaded and locked using a firearm safe, lock box, trigger lock or cable lock.		
Religious or spiritual?	Yes No If yes: Connected to a church, group, club or organization? Yes No		

Medical history:

Name of primary care physician:		
Any other specialists?		
Have you ever had a stroke or TIA?	Yes	No
Have you ever had serious head injury?	Yes	No
Have you ever had a seizure?	Yes	No
Have you ever had a concussion?	Yes	No
Have you ever had a sleep study?	Yes	No

Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date_____ Patient Name:_____ Date of Birth: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.

PHQ-9	**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 fidgety 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 in some way.	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? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.

GAD-7	**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? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

UHS Rev 4/2020

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc.
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LEC-5 Standard

Instructions: Listed below are a number of difficult or stressful things that sometimes happen to people. For each event check one or more of the boxes to the right to indicate that: (a) it happened to you personally; (b) you witnessed it happen to someone else; (c) you learned about it happening to a close family member or close friend; (d) you were exposed to it as part of your job (for example, paramedic, police, military, or other first responder); (e) you're not sure if it fits; or (f) it doesn't apply to you.

Be sure to consider your *entire life* (growing up as well as adulthood) as you go through the list of events.

Event	Happened to me	Witnessed it	Learned about it	Part of my job	Not sure	Doesn't apply
1. Natural disaster (for example, flood, hurricane, tornado, earthquake)	☐	☐	☐	☐	☐	☐
2. Fire or explosion	☐	☐	☐	☐	☐	☐
3. Transportation accident (for example, car accident, boat accident, train wreck, plane crash)	☐	☐	☐	☐	☐	☐
4. Serious accident at work, home, or during recreational activity	☐	☐	☐	☐	☐	☐
5. Exposure to toxic substance (for example, dangerous chemicals, radiation)	☐	☐	☐	☐	☐	☐
6. Physical assault (for example, being attacked, hit, slapped, kicked, beaten up)	☐	☐	☐	☐	☐	☐
7. Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb)	☐	☐	☐	☐	☐	☐
8. Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm)	☐	☐	☐	☐	☐	☐
9. Other unwanted or uncomfortable sexual experience	☐	☐	☐	☐	☐	☐
10. Combat or exposure to a war-zone (in the military or as a civilian)	☐	☐	☐	☐	☐	☐
11. Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war)	☐	☐	☐	☐	☐	☐
12. Life-threatening illness or injury	☐	☐	☐	☐	☐	☐
13. Severe human suffering	☐	☐	☐	☐	☐	☐
14. Sudden violent death (for example, homicide, suicide)	☐	☐	☐	☐	☐	☐
15. Sudden accidental death	☐	☐	☐	☐	☐	☐
16. Serious injury, harm, or death you caused to someone else	☐	☐	☐	☐	☐	☐
17. Any other very stressful event or experience	☐	☐	☐	☐	☐	☐

If you answered yes to any of these questions please go to page 5, if no to all please skip to page 6.

PCL-5

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

In the past month, how much were you bothered by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being "superalert" or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

Mood Disorder Questionnaire (MDQ)

Name: _____ **Date:** _____

Instructions: Check (☑) the answer that best applies to you.
Please answer each question as best you can.

	Yes	No
1. Has there ever been a period of time when you were not your usual self and...		
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	◯	◯
...you were so irritable that you shouted at people or started fights or arguments?	◯	◯
...you felt much more self-confident than usual?	◯	◯
...you got much less sleep than usual and found you didn't really miss it?	◯	◯
...you were much more talkative or spoke faster than usual?	◯	◯
...thoughts raced through your head or you couldn't slow your mind down?	◯	◯
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	◯	◯
...you had much more energy than usual?	◯	◯
...you were much more active or did many more things than usual?	◯	◯
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	◯	◯
...you were much more interested in sex than usual?	◯	◯
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	◯	◯
...spending money got you or your family in trouble?	◯	◯
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time? *Please check 1 response only.*	◯	◯
3. How much of a problem did any of these cause you — like being able to work; having family, money, or legal troubles; getting into arguments or fights? *Please check 1 response only.* ◯ No problem ◯ Minor problem ◯ Moderate problem ◯ Serious problem		
4. Have any of your blood relatives (ie, children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	◯	◯
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	◯	◯

This questionnaire should be used as a starting point. It is not a substitute for a full medical evaluation. Bipolar disorder is a complex illness, and **an accurate, thorough diagnosis can only be made through a personal evaluation by your doctor.**

Adapted from Hirschfeld R, Williams J, Spitzer RL, et al. Development and validation of a screening instrument for bipolar spectrum disorder: the Mood Disorder Questionnaire. *Am J Psychiatry.* 2000;157:1873-1875.

Columbia Suicide Severity Rating Scale

Please place a check mark in the box for the appropriate answers	**In the past Month**	
Please answer questions 1 and 2	**YES**	**NO**
1) Have you wished you were dead or wished you could go to sleep and not wake up?	___	___
2) Have you actually had any thoughts of killing yourself? **If <u>YES</u>, answer all questions 3, 4, 5, and 6.** **If <u>NO</u>, skip directly to question 6.**	___	___
3) Have you thought about how you might do this? *(For example, "I thought about taking an overdose but I never worked out the details about when, where, and how I would do that and I would never act on these thoughts.")*	___	___
4) Have you had any intention of acting on these thoughts of killing yourself, as opposed to you have the thoughts, but you definitely would not act on them? *(For example, "I had the thought of killing myself by taking an overdose and am not sure whether I would do it or not.")*	___	___
5) Have you started to work out, or actually worked out, the specific details of how to kill yourself and did you actually intend to carry out the details of your plan? *(For example, "I am planning to take 3 bottles of my sleep medication this Saturday when no one is around to stop me.")*	___	___
6) Have you ever done anything, started to do anything, or prepared to do anything to end your life? *(For example: Took pills, tried to shoot yourself, cut yourself, tried to hang yourself, took out pills but didn't swallow any, held a gun but changed your mind about hurting yourself or it was grabbed from your hand, went to the roof to jump but didn't, collected pills, obtained a gun, gave away valuables, wrote a will or suicide note; etc.)*	___	___
If YES, did this occur in the past 3 months?	___	___

McLean Screening Instrument for BPD

	Yes	No
1. Have any of your closest relationships been troubled by a lot of arguments or repeated breakups?		
2. Have you deliberately hurt yourself physically (e.g., punched yourself, cut yourself, burned yourself)? How about made a suicide attempt?		
3. Have you had at least two other problems with impulsivity (e.g., eating binges and spending sprees, drinking too much and verbal outbursts)?		
4. Have you been extremely moody?		
5. Have you felt very angry a lot of the time? How about often acted in an angry or sarcastic manner?		
6. Have you often been distrustful of other people?		
7. Have you frequently felt unreal or as if things around you were unreal?		
8. Have you chronically felt empty?		
9. Have you often felt that you had no idea of who you are or that you have no identity?		
10. Have you made desperate efforts to avoid feeling abandoned or being abandoned (e.g., repeatedly called someone to reassure yourself that he or she still cared, begged them not to leave you, clung to them physically)?		

Simple Screening Instrument for Substance

The questions that follow are about your use of alcohol and other drugs. Mark the response that best fits for you**. During the last 6 months** …

	Yes	No
1. Have you used alcohol or other drugs?		
Wine, beer, liquor		
Tobacco, cigarettes, e-cigarettes, nicotine, vaping		
Pot, weed, marijuana, cannabis		
Cocaine, methamphetamine, uppers		
Heroin, fentanyl, percocets or other painkillers or opioids		
Benzos, downers		
LSD, MDMA, ecstasy, mushrooms, ayahuasca, psilocybin		
2. Have you felt that you use too much alcohol or other drugs?		
3. Have you tried to cut down or quit drinking or using alcohol or other drugs?		
4. Have you gone to anyone for help because of your drinking or drug use? (Such as alcoholics anonymous, narcotics anonymous, counselor, treatment program)		
5. Have you had any health problems?		
Had blackouts or periods of memory loss?		
Injured your head after drinking or using drugs?		
Had convulsions, delirium tremens (“DTs”)		
Had hepatitis or liver problems?		
Felt sick, shaky, or depressed when you stopped?		
Felt “coke bugs” or a crawling feeling under the skin after you stopped?		
Been injured after drinking or using?		
Used needles to shoot drugs?		
6. Has drinking or other drug use caused problems between you and your family or friends?		
7. Has your drinking or other drug use caused problems at school or at work?		
8. Have you been arrested or had other legal problems? (Such as bouncing bad checks, driving while intoxicated, theft or drug possession)		
9. Have you lost your temper or gotten into arguments or fights while drinking or using other drugs?		
10. Are you needing to drink or use drugs more and more to get the effect you want?		
11. Do you spend a lot of time thinking about or trying to get alcohol or other drugs?		
12. When drinking or using drugs, are you more likely to do something you wouldn’t normally do, such as break rules, break the law, sell things that are important to you, or have unprotected sex with someone?		
13. Do you feel bad or guilty about your drinking or drug use?		
The next questions are about your lifetime experiences:		
14. Have you ever had a drinking or other drug problem?		
15. Have any of your family members ever had a drinking or drug problem?		
16. Do you feel that you have a drinking or drug problem now?		

Review of systems:

Please circle any of the following symptoms you have experienced in the last week:

General: Fever, chills, weight gain, weight loss, appetite change, fatigue, heat intolerance, cold intolerance, hot flashes

Skin: Itching, rash, color change, change in hair or nails, breast lump

Eyes: Watery eyes, blurry vision, vision changes

Ears, nose and throat: sneezing, runny nose, hearing changes, sore throat, voice change, change in smell, neck swelling

Heart and lungs: Shortness of breath, cough, wheeze, Chest pain, leg swelling, fainting

Digestive system: Indigestion, heartburn, nausea, vomiting, diarrhea, constipation, blood in stool, abdominal pain

Urinary and sexual function: urinary frequency, urinary urgency, pain with urination, incontinence, urinary retention, erectile dysfunction, low libido, pain with sex, vaginal discharge

Muscles and bones: Muscle aches/pains, back pain, weakness, broken bones

Brain and nerves: Headaches, seizures, shaking, problems walking, numbness, weakness, tingling

Blood: Easy bleeding, easy bruising, pale