



Med/Psych/SAPT Questionnaire

Client Name: _____	DOB: ___/___/___
MRN: _____	

*Are you pregnant? Yes___ No___ Refused___

*Do you have children? Yes___ No___

*Number of children currently living in household _____

*Are any of your children in need of behavioral health services? yes ___ No___ Refused ___

*Referral to: _____

*If your therapist thinks you would be appropriate for therapeutic groups would you prefer gender specific group or a group with both male/females? all male ___ all female ___ both male/female___

*Do you have a Primary Care Physician? Yes___ No___

*PCP Name: _____

*IF NO, referral to: _____ *Referral refused _____

Have you had a physical exam in the past 6 months? Yes ___ No ___ (Date of exam)_____

Are your immunizations up to date? Yes ___ No ___

*Do you have a Dentist? yes___ No___

*Dentist Name: _____

*If NO, referral to: _____ * Referral refused _____

Have you seen a dentist in the past 6 months Yes___ No___

Have you experienced any dental problems in the last 6 months? Yes ___ No___

If yes please list: _____

Please list any medical problems that affect you, past or present:

Problem	Current	Past	Treating Physician

Please list all medical hospitalizations, other than childbirth, you have had in the past 5 years:

Condition	Hospital	Date

Are you currently taking any medication (incl. over-the-counter)? Yes ___ No ___ If yes, specify:

Medication	Why Taking It	Prescriber

Have you ever taken any psychiatric medication? Yes ___ No ___ If yes, specify:

Medication	Why Taking It	Prescriber

Previous Psychiatric/Substance Abuse Treatment:

Facility	MD/Therapist	Date

Nutritional Screening: Do you experience any of the following? Please check any that apply

Binging	<input type="checkbox"/>	Purging	<input type="checkbox"/>
Excessive Exercising	<input type="checkbox"/>	Laxative Use	<input type="checkbox"/>
Absence of Menses	<input type="checkbox"/>	Compulsive Overeating	<input type="checkbox"/>
Changes in Eating Habits	<input type="checkbox"/>	Other	<input type="checkbox"/>

In the past 3 months have you had a weight loss of 10 lbs? Yes ___ No ___

In the past 3 months have you had a weight gain of 10 lbs? Yes ___ No ___

Do you have any known food allergies? Yes ___ No ___

If yes please list: _____

Pain Assessment:

Do you experience physical pain? Yes ___ No ___

Please rate your pain below:

1 – Minimal 2 - Mild 3 – Moderate 4 – Painful 5 – Severe

Where is your pain? _____

Are you being treated for your pain? Yes ___ No ___ If yes, is treatment helpful? Yes ___ No ___

Tuberculosis Screening:

(circle one)

Have you ever been told you had Tuberculosis (TB)? Yes No

If so, were you treated? Yes No

Have you ever had contact with someone who had active TB? Yes No

Is there any history of TB in your family? If so, who? _____ Yes No

Are you homeless? Yes No

Have you recently lived in a homeless shelter or jail? Yes No

Have you lived in an area of known higher prevalence of TB? Yes No

Do you know your HIV status? Yes No

Are you an IV drug user? Yes No

***If one of the above is answered "Yes", refer to physician.**

Do you presently have any of the following symptoms:

Have you had a cough (for 3 weeks or more)?	Yes	No
Do you feel weak?	Yes	No
Do you have a fever?	Yes	No
Have you had any weight loss?	Yes	No
Have you had a loss of appetite?	Yes	No
Do you have night sweats?	Yes	No
Are you coughing up blood?	Yes	No
Do you have chest pain when coughing?	Yes	No
Are you chronically malnourished?	Yes	No
Do you have diabetes?	Yes	No

***If 2 of the above are answered "Yes", refer to physician.**

Patient Signature _____ **Date** _____

To be completed by interviewing clinician:

Client has listed a medical condition necessitating further follow-up.	Yes	No
Client has listed a pain condition of 3 or more.	Yes	No
Further TB Screening is indicated.	Yes	No

***If "Yes" to any of the above, request Physician Review.**

Nutritionist referral indicated and scheduled as follows:	Yes	No
Date: _____ Time: _____		
Immunizations are up to date.	Yes	No
If no, specify: _____		

Physician Review Requested? **Yes** **No**

Signature of Interviewing Clinician _____ **Date:** _____

Physician Review:

This Medical Questionnaire was reviewed today. The patient _____ was present _____ was not present.

Recommendations:

- _____ No intervention by LifeSpring physician indicated.
- _____ Patient will be instructed to have follow-up with personal physician for _____.
- _____ Patient will be referred for further TB Screening.
- _____ Patient will be scheduled with LifeSpring physician.

Signature of Reviewing Physician: _____ **Date:** _____