WHITE OAK
Psychiatric Services

New Patient Registration Information CHILD PACKET

REVIEW OF SYSTEMS

Have you recently been troubled with any of the following symptoms?

Backache	Yes	No	Bloody Sputum	Yes	No
Leg Pain	Yes	No	Indigestion	Yes	No
Restless Leg Sensation	Yes	No	Abdominal Pain	Yes	No
Painful Joints	Yes	No	Diarrhea	Yes	No
Headaches	Yes	No	Constipation	Yes	No
Double Vision	Yes	No	Change in Bowel Habits	Yes	No
Difficulty Swallowing	Yes	No	Slow Urine Stream	Yes	No
Hoarseness	Yes	No	Abnormal Bleeding	Yes	No
Nosebleeds	Yes	No	Blood in Stool	Yes	No
Shortness of Breath	Yes	No	Pus in Urine	Yes	No
Dizziness	Yes	No	Yellow Jaundice	Yes	No
Chest Pain/Pressure	Yes	No	Depression/Anxiety	Yes	No
Irregular Heartbeat	Yes	No	Weight Gain	Yes	No
Swelling of Feet	Yes	No	How many pounds	_____	
Cough/Cold	Yes	No	Weight Loss	Yes	No
Wheezing	Yes	No	How many pounds	_____	
Vomited Blood	Yes	No	Fever	Yes	No
Sore throat	Yes	No	Rash	Yes	No
Snoring	Yes	No	Palpitations	Yes	No
Dry Skin	Yes	No	Cold/Heat intolerance	Yes	No
Clammy skin	Yes	No	Daytime Sleepiness	Yes	No

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?	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

FOR OFFICE USE ONLY 0 **+** _____ + _____ + _____

= Total Score: _____

If you circled 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
☐	☐	☐	☐