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
☐	☐	☐	☐

IF YOU HAVE EVER SMOKED

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	No	Yes
1. Have you ever tried to quit but could not?		
2. Do you smoke now because it is really hard to quit?		
3. Have you ever felt like you were addicted to tobacco?		
4. Do you ever have strong cravings to smoke?		
5. Have you ever felt like you really needed a cigarette?		
6. Is it hard to keep from smoking in places where you are not supposed to?		
When you have not used tobacco for a while or when you tried to stop smoking		
7. Did you find it hard to concentrate because you could not smoke?		
8. Did you feel more irritable because you could not smoke?		
9. Did you feel a strong need or urge to smoke?		
10. Did you feel nervous, restless, or anxious because you could not smoke?		

AUDIT

PATIENT: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential, so please be honest.

For each question in the chart below, place an X in one box that best describes your answer.

NOTE: In the U.S., a single drink serving contains about 14 grams of ethanol or "pure" alcohol. Although the drinks below are different sizes, each one contains the same amount of pure alcohol and counts as a single drink:

12 oz. of beer (about 5% alcohol) =

8-9 oz. of malt liquor (about 7% alcohol) =

5 oz. of wine (about 12% alcohol) =

1.5 oz. of hard liquor (about 40% alcohol)

Questions	0	1	2	3	4	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 to 4 times a month	2 to 3 times a week	4 or more times a week	
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have 5 or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	
					Total	

Note: This questionnaire (the AUDIT) is reprinted with permission from the World Health Organization. To reflect drink serving sizes in the United States (14g of pure alcohol), the number of drinks in question 3 was changed from 6 to 5. A free AUDIT manual with guidelines for use in primary care settings is available online at *www.who.org*.