Continuum
Mental Health & Wellness
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New Patient Health History

Please include all honest information so that we can help you to the best of our ability.

Date: _____ How did you hear about Continuum? _____

Patient Name: _____ DOB: _____

Race/Ethnicity: _____ Gender/Sexual Orientation: _____

Credit Card: _____ Exp:_____ CVV:_____

Address:_____ State:_____ Zip code(required):_____

Medication Allergies: ☐ **If none, please mark here.**

_____

Current Medications/Supplements: *(please include over the counter vitamins and herbal supplements)*

Name	Dose	Date Started	Purpose

Other Treatment Providers: *(please include **all** other Therapists, Counselors, and Medical Providers)*

Name	Specialty	Dates of Service
_____	_____	_____
_____	_____	_____
_____	_____	_____

Past Medical History: Have you ever had any of the following health conditions? If yes, please check.

Cardiovascular
- ☐Arrhythmia
- ☐Congestive Heart Failure
- ☐High Blood Pressure
- ☐Heart Disease

Endocrine
- ☐Diabetes
- ☐Thyroid Disease
- ☐Kidney Disease
- ☐Liver Disease
- ☐High Cholesterol/Lipids

Gastrointestinal
- ☐Crohn's Disease
- ☐Frequent Diarrhea
- ☐Constipation
- ☐Heartburn/GERD
- ☐Irritable Bowel Syndrome
- ☐Food Sensitivities
- ☐Food Restrictions
- ☐Purging

Musculoskeletal
- ☐Osteoarthritis

Rheumatology
- ☐Rheumatoid Arthritis
- ☐Autoimmune Disorder

Women's Health
- ☐Miscarriage
- ☐Heavy Bleeding
- ☐Irregular Periods

Neurology
- ☐Dizziness / Vertigo
- ☐Hearing Loss
- ☐Vision Loss/Impairment (cause: _____)
- ☐Headaches (frequency: _____)
- ☐Migraines
  - Frequency/Duration: _____
  - Symptoms: _____
- ☐Restless Leg Syndrome
- ☐History of Seizure
- ☐Epilepsy
- ☐Concussion (year(s): _____)
  - Loss of Consciousness? ☐Yes ☐No
- ☐Fibromyalgia

Respiratory
- ☐Sleep Apnea
- ☐Allergies
- ☐COPD/Emphysema
- ☐Asthma/Respiration Issues

Other
- ☐Anemia
- ☐Cancer (status: _____)
- ☐Chronic Pain
  - Location: _____ Onset: _____
- ☐Fainting

Other medical conditions or additional information regarding medical history:

_____

_____

_____

_____

Past Surgeries: Please list past surgeries along with the approximate month/year of the procedure.

Date(s)	Procedure
_____	_____
_____	_____
_____	_____

Past Psychiatric History: Have you ever had any of the following psychiatric problems? If yes, please check the indicated box and explain below.

☐Anxiety/Excessive Worry
☐ADHD/ADD
☐Appetite Change (increase/decrease)
☐Autism
☐Bipolar Disorder
☐Decreased Energy/Fatigue
☐Sad, Depressed Mood
☐Food Restrictions
☐Purging
☐Impulsive Behavior
☐Isolation
☐History of Abuse/Neglect
☐Excessive Weight Loss
☐Excessive Weight Gain
☐Trouble Concentrating
☐Social Anxiety
☐Learning Disability
☐Loss of Interest
☐Obsessive Compulsive (OCD)
☐Panic Attacks
☐Interpersonal Issues
☐PTSD
☐Schizophrenia
☐Sleep Changes (type: _____)
☐Self-Injuring Behavior
☐Racing Thoughts
☐Thoughts of ending your life
☐Thoughts of hurting yourself
☐Thoughts of hurting others

If you marked yes for any of the above or have any other pertinent conditions/information you wish to disclose, please explain:

_____

_____

_____

_____

_____

_____

_____

Previous Hospitalizations or Intensive Outpatient Programs: *(please give start and end dates)*

_____

_____

_____

Family History: Please list any conditions (mental or physical) diagnosed in your family. If you think a condition has gone undiagnosed, please indicate as well. All information given will better help to understand your health history. Please indicate maternal/paternal sides.

Family Member	Condition
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Substance Use: Please circle the response that best applies to you.

Tobacco/Nicotine Use? Y N **Drink Alcohol? Y N** **Caffeine? Y N**

List any other supplement/substance used in the last 30 days or use this space to explain above answers:

_____

_____

_____

_____

Additional Information: Please briefly tell me any additional information (information that was not included in the form prior or extra explanation of why you are here today) that will help us to better understand you and address your concerns.

_____

_____

_____

_____

_____

Patient Health Questionnaire (PHQ-9)

Patient Name: _____ Date: _____

Please carefully consider these questions. Over the last two (2) weeks, how often have you been bothered by any of the following problems? Please indicate a 0 for "Not at all", a 1 for "Several days within the last two weeks", a 2 for "More than half of the days in the last two weeks", or a 3 for "Nearly every day in the last two weeks". Please be as honest as you can when answering.

	Not at all	Several Days	More than half the days	Nearly every day
Little interest or pleasure in doing things	**0**	**1**	**2**	**3**
Feeling down, depressed, or hopeless	**0**	**1**	**2**	**3**
Trouble falling or staying asleep, or sleeping too much	**0**	**1**	**2**	**3**
Feeling tired or having little energy	**0**	**1**	**2**	**3**
Poor appetite or overeating	**0**	**1**	**2**	**3**
Feeling bad about yourself, or that you are a failure or have let yourself/your family down	**0**	**1**	**2**	**3**
Trouble concentrating on things, such as reading the newspaper or watching TV	**0**	**1**	**2**	**3**
Moving or speaking so slowly that other people could have noticed. Or the opposite: being so fidgety/restless that you have been moving around a lot more than usual	**0**	**1**	**2**	**3**
Thoughts that you would be better off dead, or thoughts of hurting yourself	**0**	**1**	**2**	**3**

Add columns: **_____ + _____ + _____**

Total Score: _____
(total is for professional interpretation)

If you checked off 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

Generalized Anxiety Disorder (GAD-7)

Patient Name: _____ Date: _____

Please carefully consider these questions. Over the last two (2) weeks, how often have you been bothered by any of the following problems? Please indicate a 0 for "Not at all", a 1 for "Several days within the last two weeks", a 2 for "More than half of the days in the last two weeks", or a 3 for "Nearly every day in the last two weeks". Please be as honest as you can when answering.

	Not at all	Several Days	More than half the days	Nearly every day
Feeling nervous, anxious, or on edge	**0**	**1**	**2**	**3**
Not being able to stop or control worrying	**0**	**1**	**2**	**3**
Worrying too much about different things	**0**	**1**	**2**	**3**
Trouble relaxing	**0**	**1**	**2**	**3**
Being so restless its hard to sit still	**0**	**1**	**2**	**3**
Becoming easily annoyed or irritable	**0**	**1**	**2**	**3**
Feeling afraid as if something awful might happen	**0**	**1**	**2**	**3**
Add columns:		_____ + _____ + _____		

Total Score: _____
(total is for professional interpretation)

If you checked off 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