New Patient Information Form for Dr. Olabisi

In Order to serve you better, please provide the following information:

Name : ____

LAST NAME FIRST NAME MIDDLE INITIAL

Address : ____

STREET ADDRESS CITY POSTAL CODE

Health Card # :_______-_______-_______ **Date of Birth** : ______________________ **Sex:** Male/Female

Month / Date / Year

Home # : ________________________ **Cell #** _______________________ **Work #:** ___________________

Email : ____

Next of Kin: Name & Number & Relationship to patient : Name ___________________________________

Relationship : ____

Tel. No. Home : ______________________________ Cell No. ____________________________________

Allergies:____

Family Doctor: ____ **Phone #:** ________________________

Pharmacy Name :____

Address: ____ **Phone #:** ________________________

Briefly state why you are seeking treatment and when your problems began:

____

____

____

Have you ever seen a Psychiatrist in the past ? _________ **YES** _________ **NO**

What was the name of the Psychiatrist seen? ____

When where you last seen? ____

Previous Medical/Surgery History: Tick all that apply ☐ Diabetes ☐ Heart Disease

☐ Heart Condition ☐ Eye Disease ☐ Kidney Disease

☐ Head Injury ☐ Liver Disease ☐ Joint Problem

☐ Lung Disease ☐ Skin Condition ☐ Gastrointestinal Problem

☐ Seizures ☐ Urinary problems ☐ Cancer Type _________________________

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Surgeries: ____

Social History:

Marital Status: _______ Single _______ Common Law ________ Married

_______ Separated _______ Divorced ________ Widow

Family History: (does any immediate family member have any Mental or Physical issues)

Mother ___________________________ Siblings ___________________________

Father ___________________________ Children _________________________

____

Date

Patient Name : ______________________________________ Date: ___________________

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 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
	PHQ-9 Total Score (add columns) :	**/27**	=				

Q6 CORE	I made plans to end my life in the last 2 weeks	NO	YES

GAD - 7

	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	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 is 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
	GAD-7 Total Score (add columns) :	**/21**	=				

If you have 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** ☐