

Adult New Patient Questionnaire

DEMOGRAPHIC INFORMATION:				Today's	Date:	_/	_/	
Name:								
	First			Middle	9	L	ast	
Age:					Date of Bi	rth:/	/.	
Gender:	М	F	Marital Status	s :	Single Divorced	Married Widowe		eparated
Ethnicity (C)ptional-	circle a	I that apply):					
African Ame	erican	Ame	rican Indian	Asian/	Pacific Island	ler C	Caucasiar	า
Hispanic		Mult	iracial	Other:				
Religion (O	ptional): _.							
Home Addr	ess:							
Home: ()		Cell: (_) _	<u>-</u>	Fax: ()	-
Email:								
Employer's	Name: _				Phon	e: () _		
Job Title:			Prefe	erred Wa	ay To Reach \	/ou:		



4200 Somerset Dr., Ste. 214 A Prairie Village, KS, 66208 Tel: 913-608-9482

www.carolinaapontemd.com

Where were you born?
Primary Language(s):
Preferred Language:
How long have you lived in the Kansas City Metro Area?
Emergency Contact:
Name: Relationship:
Home: () Cell: ()
Reason for Referral:
Who referred you to this office?
What are the problems for which you are seeking help?
Why seek help now?
What goal(s) do you expect psychiatric treatment will help you achieve?
How long do you expect this treatment to take?
What kind of treatment do you expect? (Talk therapy, medication, both, other):



4200 Somerset Dr., Ste. 214 A Prairie Village, KS, 66208 Tel: 913-608-9482 www.carolinaapontemd.com

MEDICAL HISTORY:

Have you ever suffered from any of the following conditions? (Circle all that apply):

Neurological: Frequent falls, Seizures, Frequent headaches, Tics, Dystonias, Parkinson's

disease, Dementia, Delirium, Stroke, Multiple Sclerosis, Encephalitis,

Meningitis

Head: Blurry Vision, Dizziness, Seasonal Allergies, Hearing loss, Frequent sinus

infections

Heart: Hypertension, Arrhythmias, Frequent shortness of breath, Palpitations,

Frequent chest pain, Heart failure, Heart murmur, Mitral valve prolapse,

Endocarditis, Heart attack, Swollen legs

Lungs: Asthma, Obstructive Sleep Apnea (OSA), Chronic cough, Emphysema,

Chronic Bronchitis, Sarcoidosis, Tuberculosis (TB)

Gastrointestinal: Reflux disease (GERD), Frequent heartburn, Ulcers, Chronic diarrhea or

constipation, Frequent stomachaches, Irritable bowel syndrome (IBS),

Crohn's disease, Ulcerative Colitis, Celiac disease, Pancreatitis, Liver disease,

Gallbladder disease

Urinary: Benign prostatic hypertrophy (BPH), Frequent blood in urine, Kidney failure,

Urinary tract infections (UTI), Kidney infections, Kidney stones, Sexually transmitted disease (STD), Sexual dysfunction, Premenstrual syndrome (PMS), Premenstrual dysphoric disorder (PMDD), Polycystic ovary syndrome

(PCOS), Infertility

Musculoskeletal: Chronic back pain, Fibromyalgia, Chronic joint pain, Arthritis, Gout,

Osteoporosis, A significant bone fracture

Skin: Eczema, Severe or persistent rash, Psoriasis, Bed sores, Cellulitis

Immunologic: Cancer, HIV, Hepatitis B, Hepatitis C, Lupus, Lyme disease

Endocrine: Diabetes, Hypothyroidism, Hyperthyroidism, Elevated Cholesterol, Elevated

Triglycerides, Obesity

4200 Somerset Dr., Ste. 214 A Prairie Village, KS, 66208 Tel: 913-608-9482 www.carolinaapontemd.com

Do you suffer from any other chro	onic illnes	s not listed a	bove? (Please list):	
Who is your current Primary Care	Physiciar	n?		
Date of your last physical exam? _				
SURGICAL HISTORY: (Please list a	ll surgerie	es with appro	oximate dates)	
Accidents:				
Have you ever sustained any signi	ficant he	ad injury? Y	N	
When did the head injury (ies) occ	cur?			
How did the head injury (ies) hap	pen?			
Did you loose consciousness?	Υ	N	For how long?	

CURRENT MEDICATIONS: (Please include all prescription drugs as well as over the counter medications, vitamins and supplements – Use the back of this page if needed)

Name	Indication	Dosage	Duration of Treatment	Side Effects

ALLERGIES:	
PAST MENTAL HEALTH HISTORY:	
Have you ever received psychiatric treatment? Y	N
If yes, please describe any intervention you have previously i	received:
Please list prior diagnoses:	

Please indicate if you have received any of the following treatments and their effectiveness:

Type of Therapy	Level of Improvement with Therapy				
Psychodynamic Psychotherapy	Much	Some	None		
Psychoanalysis	Much	Some	None		
Cognitive Behavioral Therapy (CBT)	Much	Some	None		
Dialectical Behavior Therapy (DBT)	Much	Some	None		
Interpersonal Therapy (IPT)	Much	Some	None		
Family/ Couples Therapy	Much	Some	None		
Other	Much	Some	None		



4200 Somerset Dr., Ste. 214 A
Prairie Village, KS, 66208
Tel: 913-608-9482
www.carolinaapontemd.com

Have you ever been hospitalized for a psychiatric condition? Y N

If yes, please specify dates and circumstances:

Name of Institution where admitted	Approximate dates	Circumstances that lead to hospitalization

Please list, to the best of your recollection, any and all psychiatric medications you have ever taken (Use the back of this paper if necessary):

Name	Indication	Dosage	Duration of Treatment	Side Effects

FAMILY HISTORY: (Please list any blood relatives who currently struggle with or have been treated for any mental illness and/ or psychological, emotional or behavioral difficulties or problems with use or abuse of substances such as alcohol or drugs.)

Relationship to You		List of	Disorde	rs	
Do medical illnesses run in your family? (E.g	. seizures, thyroid	problems, e	tc.)	Y N	
If yes, please list the illness and the family m	nembers that suffe	er from this i	llness: _		
SOCIAL HISTORY AND PERSONAL HABITS:					
Have you ever served in the Armed Forces, a	active duty or rese	erve?	Υ	N	
Have you ever experienced or witnessed a to physical abuse, or any other extremely upse		ch as comba Y	t, rape, s N	sexual abuse,	
How many cups, glasses, or cans of caffeinate	ted products do y	ou drink per	day?		
	7	© Car	olina Apor	nte Urdaneta, MD,	LLC



4200 Somerset Dr., Ste. 214 A Prairie Village, KS, 66208 Tel: 913-608-9482

www.carolinaapontemd.com

How many glasses, cans, or bottles of alcoholic beverages do you drink per month on average? Between 1-3 Between 3-10 Between 10-20 Between 20-40 More than 40 Have you ever tried to cut down your use of alcohol? Υ Have you ever felt guilty about using alcohol? Υ Ν How often do you gamble? (Sports betting, racetrack, cards, casino, etc.): _____ Do you smoke? If yes, how much do you smoke per week? Υ N Have you ever overused/ abused any street drugs, prescription drugs or over the counter medications? If yes, please explain: Have you ever used anabolic steroids?Y Ν Is anyone that you are in a close relationship with abusing drugs and/or alcohol? What activities do you engage in regularly for fun? ______ Do you exercise regularly? Y How frequently? _____ N What do you typically do to de-stress? Please describe your sleep (circle all that apply):

Difficulties initiating sleep

Poor

Excessive

Nighttime awakenings

Restless

Restful

No difficulties



Carolina Aponte Urdaneta, MD, LLC 4200 Somerset Dr., Ste. 214 A Prairie Village, KS, 66208

Tel: 913-608-9482 www.carolinaapontemd.com

Home Environment: (Please list every member of your household)

Name	Relationship to You	Age	Living at Home: Y or N		
Do you have children?	Y N	If so, how many?			
If divorced, who has cust	tody? MotherFather	Joint custody			
	Neither- ple	ease specify:			
Are any of your children	adopted? Y N				
If yes, please describe th	e circumstances of the ad	option:			
Have you lost a child? Y	N				
Do any of your children have special needs? Y N					
If so, please describe:					

Ν

4200 Somerset Dr., Ste. 214 A Prairie Village, KS, 66208 Tel: 913-608-9482

www.carolinaapontemd.com

Legal History:							
Have you ever been co		Υ	N				
Have you ever assaulte	ed anyone?	Υ	N				
Have you ever been in	Have you ever been investigated by the Department of Social Services (DSS) or the Department of						
Child and Family Service	ces (DCFS)?		Υ	N			
Are you currently invo	lved in any legal case(s));		Υ	N		
Have you ever applied	for a gun permit?		Υ	N			
Do you currently own	a gun?	Υ	N				
Education:							
Please circle the highe	st level of education ac	hieved:					
Some High School	High School Diploma		Some l	Jndergr	aduate College		
Technical Training	Associate Degree	Bachel	or's Deg	ree	Master's Degree		
Doctorate	Professional Degree (N	MD, JD,	DMD)				
Name of institution yo	u currently attend/ you	ı last att	ended:				
Date you graduated/ expect to graduate:							
How do you rate your	performance at the ins	titution	mentio	ned abo	ve?		
Poor	Fair	Good			Other		
Do you have any learning disabilities or attention problems? Y N If yes, please explain your specific disabilities and indicate when you were diagnosed:							

Work:				
Are you currently e	mployed? Y	N	Occupation:	
How long have you	been with you	r current em	ployer?	
How would you des	scribe your curr	ent level of j	ob satisfaction?	
Very satisfied	Satisfied	Average	Dissatisfied	Very dissatisfied
If you are not curre	ntly employed,	which of the	e following describes you	u? (check all that apply)
Retired	Stay	y at home pa	rent	Looking for work
Student	Car	ing for sick /	elderly relative	Other
OTHER: Please shar	re any addition	al informatio	on or concerns that you	think may be relevant for