Desert Wise, LLC • 1201 Eubank Blvd NE, Ste. 1 • Albuquerque, NM 87112

Patient Background Information Questionnaire

Please fill out form completely. If an item does not apply write "N/A." Do not write in the shaded areas.

1. General Patient Information

Today's Date: (MM/DD/YYYY)		DOB: (MM/DD/YYYY)	Age:
Patient Name:		Gender:	Ethnicity:
Street Address:			Social Security Number:
City, State, Zip Code:			
Home/Cell Phone:	Can a voicemail from Dr. Henrie be left on this phone? ☐Yes ☐No	Work Phone:	Can a voicemail from Dr. Henrie be left on this phone? ☐Yes ☐No
Email:		Can Dr. Henrie email you? ☐Yes ☐No *(As noted in Desert Wise's Informed Consent, email is not considered a confidential form of communication.)*	
List any concerns you have about confidentiality/privacy/your patient rights:		Do you feel coerced in any way to be here? ☐Yes ☐No If so, please explain:	
Who referred you to Dr. Henrie?		If no one referred you, how did you learn about Dr. Henrie?	
Emergency Contact Name:	Relationship to You:	Emergency Contact Number(s):	

2. Primary Concern/Problem

Describe the primary concern/problem that brought you here:	*Provider use only*:
How long have you been experiencing this concern/problem?	
What, if anything, caused or was associated with the start of this concern/problem?	
Has the concern/problem gotten worse, better, or stayed about the same over time?	
What solutions, if any, have been helpful in resolving this concern/problem?	
What solutions, if any, have not been helpful in resolving this concern/problem?	
What led to your decision to seek help now?	
Who do you prefer to confide in?	

3. Psychological Functioning

In a single word, describe your mood over the past 2 weeks:			*Provider use only*:
Are you currently feeling helpless or hopeless? If so, please describe:	Yes ☐	No ☐	
Over the past week, have you had thoughts of killing yourself?	Yes ☐	No ☐	
Over the past week, have you had thoughts of killing someone else?	Yes ☐	No ☐	
Have you *ever* intentionally tried to kill yourself?	Yes ☐	No ☐	
Have you *ever* intentionally cut, burned, or otherwise harmed yourself?	Yes ☐	No ☐	
Has anyone close to you ever completed suicide?	Yes ☐	No ☐	
Do you currently own a firearm or plan to acquire one?	Yes ☐	No ☐	

4. Mental Health History

Have you *ever* received counseling or other mental health/substance abuse treatment? If yes, please describe:	Yes ☐	No ☐	*Provider use only*:
Have you *ever* been hospitalized for psychiatric reasons? If yes, please describe:	Yes ☐	No ☐	
Have you *ever* been prescribed medications to change your mood, thoughts, behaviors, or sleep (irrespective of who prescribed the medications)? If yes, please list names & timeframes of medications:	Yes ☐	No ☐	
Does anyone in your family have a history of substance abuse, depression, or any other mental health condition? If yes, please describe:	Yes ☐	No ☐	
Are you currently under the care of a psychiatrist? If yes, please write the name of your psychiatrist:	Yes ☐	No ☐	

5. Medical History

Who is your primary care provider (e.g., PCM, PCP, family doctor)?			*Provider use only*:
Is your primary care provider affiliated with a clinic/group practice? If yes, which one?	Yes ☐	No ☐	
Would you like Dr. Henrie to provide updates about your mental health care to your primary care provider?	Yes ☐	No ☐	
Have you *ever* had any surgeries? If yes, please list:	Yes ☐	No ☐	
Do you have any serious and/or chronic medical diagnoses? If yes, please list:	Yes ☐	No ☐	

Are your immunizations current?	Yes ☐	No ☐	
Are you currently taking any prescription, over the counter, supplements, or herbal medicines? If yes, please list:	Yes ☐	No ☐	
Do you have any food or drug allergies? If yes, please list:	Yes ☐	No ☐	
Are you currently experiencing any chronic pain? If yes, where? Rate this pain: (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Imaginable Pain)	Yes ☐	No ☐	

6. Personal and Social History

Where were you born?	Where were you raised?		*Provider use only*:
Who were you raised by?	Number of Siblings:	Birth Order Number:	
Are your parents divorced? ☐Yes ☐No If yes, how old were you?	Were you adopted? ☐Yes ☐No If so, at what age?	Were you ever placed in foster care? ☐Yes ☐No If so, at what age?	

In the last year, have you been physically hurt or abused?	Yes ☐	No ☐
Have you *ever* been in an abusive relationship? If yes, when?	Yes ☐	No ☐
Did you experience any abuse in childhood?	Yes ☐	No ☐
Have you *ever* had legal problems? If yes, please describe:	Yes ☐	No ☐
Have you *ever* had financial problems? If yes, please describe:	Yes ☐	No ☐

7. Immediate Family

Are you married? ☐Yes ☐No	How many total times have you been married?	*Provider use only*:
Have you had a spouse precede you in death? ☐Yes ☐No If so, when?	If married, spouse's name and age:	
If not married, are you currently in a relationship? ☐Yes ☐No *(If no, skip to section about children.)*	Length of current marriage or relationship:	
How would you rate your overall satisfaction with your marriage/relationship? (Very Unsatisfied) 1 2 3 4 5 (Very Satisfied)		
What challenges, if any, do you have in your relationship?		
What strengths do you have in your relationship?		

If you have children, please list them below:

Child's Name	Age	Special Needs, if any:	Gender		Living with You?		Is this your stepchild?	
			M	F	Yes ☐	No ☐	Yes ☐	No ☐

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(Children, continued)

Child's Name	Age	Special Needs, if any:	Gender		Living with You?		Is this your stepchild?	
			M	F	Yes ☐	No ☐	Yes ☐	No ☐
			M	F	Yes ☐	No ☐	Yes ☐	No ☐
			M	F	Yes ☐	No ☐	Yes ☐	No ☐
			M	F	Yes ☐	No ☐	Yes ☐	No ☐

Is there anyone else currently living in your home? ☐Yes ☐No
If yes, please list:

8. Group Identities

Do you have any continued involvement in religious or spiritual activities? If yes, what is your affiliation?		Yes ☐	No ☐	*Provider use only*:
Do you have any religious practices or concerns that may alter your care? If yes, please describe:		Yes ☐	No ☐	
If you are no longer involved in religious or spiritual activities, but you have a past faith-based affiliation that is important to your care, please mark yes:	N/A ☐	Yes ☐	No ☐	
Do you have a cultural affiliation that is important to your identity? If yes, what is your affiliation?		Yes ☐	No ☐	
Are there any other affiliations or aspects of your identity that are important to your care? If yes, please list and/or describe:		Yes ☐	No ☐	

9. Education and Occupation

What is the highest level of education you have completed?			*Provider use only*:
If you have completed any college, please list your major(s)/degree(s):			
Did you have any learning or behavioral problems while in school? If yes, please describe:		Yes ☐	No ☐
What is your current job/profession?			
How would you rate your overall satisfaction with your current job? (Very Unsatisfied) 1 2 3 4 5 (Very Satisfied)			
What challenges, if any, do you have in your current job?			
What strengths do you have in your current job?			

10. Treatment Goals

Briefly describe things you wish to accomplish during your treatment:

1.

2.

3.

11. Military Service

(Note: If you or your spouse are not in the military and are not military veterans, leave this section blank.)

Are you currently in the military? ☐YES ☐NO If no, are you a military veteran? ☐YES ☐NO *(If yes to either, complete section 11a.)*	Is your spouse currently in the military? ☐YES ☐NO If no, is your spouse a military veteran? ☐YES ☐NO *(If yes to either, complete section 11b.)*

11a. Military Service Information about Yourself

Branch of Service: ☐ USAF	☐ USA	☐ USN	☐ USMC	☐ USCG	☐ USPHS	Rank/Grade:	
Current Duty Status:	☐ Active Duty	☐ Guard	☐ Reserve	☐ Retired	☐ Separated		
Mo/Yr of Service Entry:	Mo/Yr of Retirement or Separation:	If currently AD, Time on Station:				*Provider use only*:	
Current/Most Recent Unit/Organization:		Duty Title: AFSC/MOS:					
Have you been tasked with any deployments? If yes, list deployment locations and dates:				Yes ☐	No ☐		
Were you sent home early from any deployments for any reason? If yes, please describe:			N/A ☐	Yes ☐	No ☐		
Have you ever had any disciplinary issues (including PT failures)? If yes, please describe:				Yes ☐	No ☐		
Have you ever received any notable commendations and/or awards? If yes, please describe:				Yes ☐	No ☐		

11b. Military Service Information about Your Spouse

(Fill in the information you know. Write "?" or "ukn" for the information you don't know.)

Spouse's Branch of Service: ☐ USAF	☐ USA	☐ USN	☐ USMC	☐ USCG	☐ USPHS	Spouse's Rank/Grade:	
Spouse's Duty Status: ☐ Active Duty	☐ Guard	☐ Reserve	☐ Retired	☐ Separated	☐ Deceased		
Spouse's Mo/Yr of Service Entry:	Spouse's Mo/Yr of Retirement or Separation:	Spouse's Time on Station (i.e., time at current duty location), if Active Duty:				*Provider use only*:	
Spouse's Current/Most Recent Unit/Organization:		Spouse's Duty Title: Spouse's AFSC/MOS:					
Did your spouse go on any deployments? If yes, list deployment locations and dates:				Yes ☐	No ☐		
Was your spouse sent home early from any deployments for any reason? If yes, please describe:			N/A ☐	Yes ☐	No ☐		
Has your spouse ever had any disciplinary issues (including PT failures)? If yes, please describe:				Yes ☐	No ☐		
Has your spouse ever received any notable commendations and/or awards? If yes, please describe:				Yes ☐	No ☐		