TOTALCARE™
BEHAVIORAL HEALTH

PATIENT QUESTIONNAIRE

Chief Complaint: _____

Severity: Mild | Moderate | Severe OR 1 (best) 2 3 4 5 6 7 8 9 10 (worse)

When did your symptoms/condition start? _____ days | weeks | months | years

How long do your symptoms last? _____ hours | weeks | months | years

What brings on your symptoms/condition?

_____

What makes your symptoms/condition better?

_____

What makes your symptoms/condition worse?

_____

Has your appetite: Decreased | Increased

Are you in possession of firearms? Yes | No

Do you have suicidal thoughts? Yes | No
If Yes, do you have a plan?_____

Do you have homicidal thoughts? Yes | No
If Yes, do you have a plan?_____

Have you had any changes to your Family, Medical or Social History? Yes | No
If Yes, please list all changes._____

_____

_____

Is your current medication improving your overall quality of life? Yes | No

How are you sleeping?_____

Additional information for our provider? _____

_____

_____

_____

_____

_____