

Depression Questionnaire - Southern California

Please complete this online form and click "Send Form" at the end to send to our secure server.

**** ALL RED STARRED QUESTIONS MUST HAVE AN ANSWER (write "None" if applicable) OR ELSE THE QUESTIONNAIRE WILL NOT BE PROCESSED THROUGH THE SYSTEM ****

*** Required**

1. Email address *

2. How did you find out about Klarity Clinic? *

Mark only one oval.

- Referred by a health care provider
- Referred by friends or family
- Google or other web search
- Facebook or other social media
- Yelp
- Radio
- Magazine or print media
- Television/News
- Other: _____

Contact Information

3. First Name *

4. Last Name *

5. Date of Birth *

Example: January 7, 2019

6. Phone *

7. Home Address *

8. City/State/Zip *

Mental Health Information

9. My current Mental Health Provider is a: *

(Please check all that apply)

Check all that apply.

- Psychiatrist
- Psychologist
- Primary Care Physician
- Therapist
- I have no Mental Health Provider at this time

10. Mental Health Provider Name

(If self-referred or referred by someone other than a clinician, please tell us your source)

11. Mental Health Provider Phone Number

12. Mental Health Provider Address

13. Primary Care Provider Name

14. Primary Care Provider Phone Number

15. Primary Care Provider Address

16. Principle Psychiatric Diagnosis and Other Psychiatric Diagnoses *

17. Psychiatric Medications *

(Please list Dose and Frequency)

18. Have you ever attempted suicide in the past? *

Mark only one oval.

No

Yes

19. Are you currently suicidal? *

Mark only one oval.

No

Yes

Medical History

20. What is your height? *

21. What is your weight? *

22. Medical Conditions

(Please check all that apply)

Check all that apply.

- High Blood Pressure
- Heart Disease
- Chest Pains / Angina
- Congestive Heart Failure
- Irregular Heart Rhythm
- Asthma
- Difficulty Exercising
- COPD/Emphysema/Chronic Bronchitis
- Using Home Oxygen
- Pulmonary Hypertension
- Diabetes
- Thyroid Problems
- Seizures
- Stroke / TIA
- Headaches
- Cognitive Problems
- Visions / Voices
- Dementia
- Dizziness / Fainting
- Numbness / Tingling
- Unsteady Gait
- Other Neurological Conditions
- Acid Reflux
- Abdominal Pain
- Nausea / Vomiting
- Other GI Conditions
- Chronic Pain
- Abnormal Bleeding / Clotting Disorder
- Anemia
- Kidney Problems
- Liver Problems
- Gynecologic Issues
- Muscle Disorders
- Bone / Joint Disorders
- Immunity Issues

Infectious Diseases

23. Are you pregnant?

Mark only one oval.

No

Yes

N/A

24. If not, when was your last menstrual period?

Example: January 7, 2019

25. Breastfeeding

(If applicable, are you breastfeeding?)

Mark only one oval.

No

Yes

26. Please list any other medical conditions not noted above and/or explanations of the conditions above that you feel would be helpful for us to know.

27. Current Non-Psychiatric Medications *

28. Previous Surgeries *

29. Have you or your direct family members ever had a serious adverse reaction to anesthesia? *

Mark only one oval.

No

Yes

30. If so, what was the reaction and whom did it happen to?

31. Allergies *

32. Tobacco Use *

Mark only one oval.

No

Yes

33. Do you drink more than 2 alcoholic beverages per day? *

Mark only one oval.

No

Yes

34. Do you use recreational drugs? *

(If applicable, list drug and when last used)

35. Have you ever been treated for substance abuse?

(Please check all that apply)

Check all that apply.

Drug

Alcohol

Patient Attestation

By submitting this form, I certify that I have completed this Questionnaire to the best of my ability.

I agree to seek immediate help should my symptoms worsen or I experience an increase in suicidal thoughts, feelings or urges.

I authorize a representative from Klarity Clinic of Southern California to contact me to discuss treatment options for my condition(s). I also understand that the staff of Klarity Clinic of Southern California may not start and maintain any prescribed treatment regimen if I am not currently under the care of a Health Professional and maintain such care until the completion of my course of treatment. I also consent to receiving emails from Klarity Clinic for marketing purposes and I may opt out at anytime in the future by unsubscribing from Klarity's marketing list.

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