

Depression Questionnaire - Northern 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 *

Contact Information

2. First Name *

3. Last Name *

4. Date of Birth *

Example: December 15, 2012

5. Phone *

6. Home Address *

7. City/State/Zip *

Mental Health Information

8. 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

9. Mental Health Provider Name

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

10. Mental Health Provider Phone Number

11. Mental Health Provider Address

12. Primary Care Provider Name

13. Primary Care Provider Phone Number

14. Primary Care Provider Address

15. Principle Psychiatric Diagnosis and Other Psychiatric Diagnoses *

16. Psychiatric Medications *

(Please list Dose and Frequency)

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

Mark only one oval.

- No
- Yes

18. Are you currently suicidal? *

Mark only one oval.

- No
- Yes

Medical History

19. What is your height? *

20. What is your weight? *

21. 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

22. Are you pregnant?

Mark only one oval.

- No
- Yes
- N/A

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

Example: December 15, 2012

24. Breastfeeding

(If applicable, are you breastfeeding?)

Mark only one oval.

- No
- Yes

25. 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.

26. Current Non-Psychiatric Medications *

27. Previous Surgeries *

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

Mark only one oval.

- No
- Yes

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

30. Allergies *

31. Tobacco Use *

Mark only one oval.

- No
- Yes

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

Mark only one oval.

- No
- Yes

33. Do you use recreational drugs? *

(If applicable, list drug and when last used)

34. 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 Depression 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 Northern California to contact me to discuss treatment options for my condition(s). I also understand that the staff of Klarity Clinic of Northern California may not start and maintain any prescribed treatment regimen if I am not currently under the care of a Mental 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.

A copy of your responses will be emailed to the address you provided

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