Depression Questionnaire - Denver

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 Denver to contact me to discuss treatment options for my condition(s). I also understand that the staff of Klarity Clinic of Denver 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