CHOKKA CENTER
FOR INTEGRATIVE HEALTH

CH003P

Brief History **Questionnaire**

Chokka Center
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become @chokkacenter.com

Please be advised that this questionnaire will require approximately ***30 – 45 minutes to be completed***. We ask that you embrace the questions with as open and direct answers you can, in the benefit of your care and whole experience to become.

~ Dr. Pratap Chokka, MD FRCPC

This document once completed can be submitted via direct link, email to: become@chokkacenter.com or by fax to: 780-465-5799.

Please note: if you have any problems completing, please contact reception via telephone at: 780-465-5749. We are happy to provide clarification with regards to completion of this important questionnaire.

Section 1: Declaration

Notification of Collection of Personal Health Information & Consent to Treatment & Disclosure of Identifying Health Information

When you receive health services of any kind from this clinic, we collect individually identifying personal information and health information from you and share this within the Clinic and with other health service providers that need the information to provide you with health services. Your identifying information may be used for internal research purposes, to inform the services provided to you or offered within our clinic. In rare cases, disclosure of information may be required by law.

The personal health information that you provide to us is collected, used and disclosed in accordance with the provisions of the Health Information Act (HIA), and is primarily used to provide diagnostic, treatment and care services to you, and to bill the Alberta Health Care Insurance Plan for services provided. The privacy provisions of the legislation require that we protect your health information from unauthorized access, use, disclosure or destruction. If you have any questions concerning the protection of your privacy and confidentiality, do not hesitate to contact us at the number on this page, or via e-mail at become@chokkacenter.com.

I, _____ acknowledge that I have been made aware of the reasons for the disclosure of the above information, and the risks and benefits associated with consenting to its release. By entering your name electronically TWICE you confirm your consent:

Patient Declaration:

This double-entry digital signature confirms your consent for the Chokka Center for Integrative Health to collect your personal and health information.

Patient Name:

Repeat Patient Name:

Date:

D D / M M / Y Y Y Y

Section 2: Your Details

Please complete these details as accurately as possible. If any details change during the year, please let us know.

Personal Details

Please complete all fields as indicated.

Given Name:

Age:

Date of Birth:

D D / M M / Y Y Y Y

Health Care Number:

Occupation:

Marital Status: (single, separated, divorced, married, widowed)

Children: (number, ages, gender) **OPTIONAL**

Contact Details

Please complete all fields and indicate if you may be contacted by text message

Home Address:

Postal Code:

Home Number:

Mobile Phone Number:

Text Option:

Yes **No**

email address:

Emergency Contact / Phone Number:

Section 3: History & Background

Presenting Concerns

Please be specific on what you want to discuss with our team, please write as much as you feel necessary

Disccusion areas:

Psychiatric History

Any previous therapies and psychiatric conditions including alcohol, drugs and agency involvement

Please Describe:

Medical History

Any medical conditions, surgery, obstetrical history, bleeding, seizures, etc.

Please Describe:

Section 3: History & Background continued

Allergies

Please include all allergies to medication, food, etc.

Please Describe:

Current Medication

Please include over-the-counter medication, non-prescription, prescription, and herbal medications

Please Describe:

Past Psychiatric Medication & Treatments

Please include all anti-depressants, mood stabilizers, ECT, etc.

Please Describe:

Family History

Please include significant mental health and medical history including alcohol and drug usage

Please Describe:

Developmental History

Place of Birth

City:

Province/State:

Country:

Developmental delays, personality as a child (i.e. Introverted, extroverted, moody, hyper, shy, anxious, etc.)?

Please Describe:

Section 3: History & Background continued

Personal Upbringing

What was it like to grow up in your family?

Please Describe:

Describe your relationship with your parents and siblings as it is now

Please Describe:

Did you experience any trauma while growing up?

Please Describe:

Legal problems (past, current, including probation)?

Please Describe:

Support system and any support you received and from whom

Please Describe:

Section 3: History & Background continued

Relationship History

Include friendships, dating, number of significant relationships, common-law or marital history including children

Please Describe: as well, describe your relationships and sexual experiences

Educational History

Indicate educational achievements and qualifications

Please Describe:

Volunteer Work

Are you volunteering, if so please describe

Please Describe:

Hobbies And Interests

Please Describe:

Current Involvement In Service Agencies

Including social assistance, workman's compensation board, disability insurance, etc.

Please Describe:

Strengths

What personal qualities do you have that help you cope?

Please Describe:

Section 4: Moving Forward

Goals

What do you hope to achieve from this consultation?

Please Describe:

Level of Interest in the Following:

Please Rate (scale 1-10):

- **Individual Therapy**
- **Group Therapy**
- **Nutrition Therapy**
- **Fitness Intervention**
- **Complementary/Holistic Therapies**
- **Motivation to Change**

Section 5: WHODAS 2.0

World Health Organization - Disability Assessment Schedule 2.0 [Adapted]

This questionnaire asks about difficulties due to health conditions. Health conditions include diseases or illnesses, other health problems that may be short or long lasting, injuries, mental or emotional problems, and problems with alcohol or drugs. Think back over the past 30 days and answer these questions, thinking about how much difficulty you had doing the following activities. For each question, mark one response.

	In the past 30 days, how much difficulty did you have in:	None	Mild	Moderate	Severe	Extreme
S1	Standing for long periods such as 30 minutes?	●	○	○	○	○
S2	Taking care of your household responsibilities?	●	○	○	○	○
S3	Learning a new task—for example, learning how to get to a new place?	●	○	○	○	○
S4	How much of a problem did you have joining in community activities *(for example, festivities, religious or other activities)* in the same way as anyone else can?	●	○	○	○	○
S5	How much have you been emotionally affected by your health problems?	●	○	○	○	○
S6	Concentrating on doing something for ten minutes?	●	○	○	○	○
S7	Walking a long distance such as a kilometre [or equivalent]?	●	○	○	○	○
S8	Washing your whole body?	●	○	○	○	○
S9	Getting dressed?	●	○	○	○	○
S10	Dealing with people you do not know?	●	○	○	○	○
S11	Maintaining a friendship?	●	○	○	○	○
S12	Your day-to-day work?	●	○	○	○	○

	Answer and record your best estimate number out of 30 in the right column.	Number of Days
H1	Overall, in the past 30 days, how many days were these difficulties present?	
H2	In the past 30 days, for how many days were you totally unable to carry out your usual activities or work because of any health condition?	
H3	In the past 30 days, not counting the days that you were totally unable, for how many days did you cut back or reduce your usual activities or work because of any health condition?	

Section 6: Sheehan Disability Scale

A brief, patient rated measure of disability and impairment

	Not at All	Mildly			Moderately			Markedly			Extremely
	0	1	2	3	4	5	6	7	8	9	10
Work* / School The symptoms have disrupted your work/school work:	●	○	○	○	○	○	○	○	○	○	○

Please Select Yes or No: I have not worked/studied at all during the past week for reasons unrelated to the disorder (*work includes paid, unpaid volunteer work, or training.)

☐ **Yes** ☐ **No**

Social Life The symptoms have disrupted your social life/leisure activities	●	○	○	○	○	○	○	○	○	○	○
Family Life / Home Responsibilities The symptoms have disrupted your family life/home responsibilities:	●	○	○	○	○	○	○	○	○	○	○
Add the score for each column											
TOTAL SCORE (add all column scores)											

Days Lost

On how many days in the last month did your symptoms cause you to miss school or work or leave you unable to do your normal daily activities?

Answer:

Days Unproductive

On how many days in the last month did you feel so impaired by your symptoms, that even though you went to school or work, your productivity was reduced?

Answer:

Section 7: Patient Health Questionnaire (PHQ-9)

Guide For Interpreting PHQ-9 Scores

1. Over the last 2 weeks, how often have you been bothered by the following problems? Read each item carefully and enter an X in the box below the numerical value that best represents your situation.	Not at All 0	Several Days 1	More than Half the Days 2	Nearly Every Day 3
a. Little interest or pleasure in doing things	●	○	○	○
b. Feeling down, depressed, or hopeless	●	○	○	○
c. Trouble falling asleep, staying asleep, or sleeping too much	●	○	○	○
d. Feeling tired or having little energy	●	○	○	○
e. Poor appetite or overeating	●	○	○	○
f. Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down	●	○	○	○
g. Trouble concentrating on things such as reading the newspaper or watching television	●	○	○	○
h. Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual	●	○	○	○
i. Thinking that you would be better off dead or that you want to hurt yourself in some way	●	○	○	○
Total for each column				
TOTAL SCORE (add your column scores)				
2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	●	○	○	○

Scale: **0-4** None to Minimal | **5-14** Mild | **15-19** Moderate | **20-27** Severe

Section 8: Mood Disorder

Please answer each question to the best of your ability

1. Has there ever been a period of time when you were not your usual self and…

you felt so good or so hyper that other people thought you were not your normal self or you were so hyper you got into trouble?	Yes	No
you were so irritable that you shouted at people or started fights or arguments?	Yes	No
you felt much more self-confident than usual?	Yes	No
you got much less sleep than usual and found you didn't really miss it?	Yes	No
you were much more talkative or spoke much faster than usual?	Yes	No
thoughts raced through your head or you couldn't slow your mind down?	Yes	No
you were so easily distracted by things around you that you had trouble concentrating or staying on track?	Yes	No
you had much more energy than usual?	Yes	No
you were much more active or did many more things than usual?	Yes	No
you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	Yes	No
you were much more interested in sex than usual?	Yes	No
you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	Yes	No
spending money got you or your family into trouble?	Yes	No

2. If you checked **YES** to more than one of the above, have several of these ever happened during the same period of time? Yes No

3. How much of a problem did any of these cause you – like being unable to work; having family, money or legal troubles; getting into arguments or fights?

Pick from four options below and type your answer here:

● No Problem ○ Minor Problem ○ Moderate Problem ○ Serious Problem

4. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder? Yes No

5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder? Yes No

Section 9: LEAPS

Lam Employment Absence and Productivity Scale

Although all forms of work including house work, child care, and others are important, the next questions are about the employed or self-employed paid work that you may do. Please do not include house work, volunteer work, or school work.

1. What kind of paid work do you do?

2. Over the past 2 weeks, how many hours were you scheduled or expected to work?

3. Over the past 2 weeks, how many hours of work did you miss because of the way you were feeling?

4. Over the past 2 weeks, how often at work were you bothered by any of the following problems?
Please limit your answers to the time when you were at work. Check the appropriate box:

	None of the time (0%)	Some of the time (25%)	Half the time (50%)	Most of the time (75%)	All of the time (100%)
	0	1	2	3	4
a. Low energy or motivation	●	○	○	○	○
b. Poor concentration or memory	●	○	○	○	○
c. Anxiety or irritability	●	○	○	○	○
d. Getting less work done	●	○	○	○	○
e. Doing poor quality work	●	○	○	○	○
f. Making more mistakes	●	○	○	○	○
g. Having trouble getting along with people, or avoiding them	●	○	○	○	○
Total for each column					
TOTAL SCORE (0-28)					

Scale: **0-5** None to Minimal | **6-10** Mild | **11-16** Moderate | **17-22** Severe | **23-28** Very Severe

Section 10: Pittsburgh Sleep Quality Index

Your usual sleep habits during the past month

Your answers should indicate the most accurate reply for the majority of the days and nights in the past month. Please answer all questions. During the past month:

1. When have you usually gone to bed?

2. When have you usually gotten up in the morning?

3. How long (in minutes) has it taken you to fall asleep each night?

4. How many hours of actual sleep did you get that night? (this may be different from the number of hours you spend in bed).

		Not during the past month	Less than once per week	Once or twice a week	Three or more times a week
During the past month how often have you had trouble sleeping because you:		0	1	2	3
A	can't get to sleep within 30 min	●	○	○	○
B	wake up in the middle of the night or early morning	●	○	○	○
C	have to get up to use the bathroom	●	○	○	○
D	can't breathe comfortably	●	○	○	○
E	cough or snore loudly	●	○	○	○
F	feel too cold	●	○	○	○
G	feel too hot	●	○	○	○
H	have bad dreams	●	○	○	○
I	have pain	●	○	○	○
J	other reasons? If so, please list and indicate how often:				
During the past month, how often have you taken medication (prescribed or over the counter) to help you sleep?		●	○	○	○
During the past month, how often have you had trouble staying awake while driving, eating meals, or engaging in social activity?		●	○	○	○
During the past month, how much of a problem has it been for you to keep up enthusiasm to get things done?		●	○	○	○
		Very Good	Fairly Good	Fairly Bad	Very Bad
During the past month, how would you rate your overall sleep quality?		●	○	○	○

Section 11: Perceived Deficits (PDQ-5)

Your cognitive function during the past 4 weeks.

Please mark the appropriate response marked with a corresponding numerical value based on your cognitive function during the past 4 weeks. Please answer every question. If you are not sure which answer to select, please choose the one answer that comes closest to describing you.

During the past 4 weeks, how often did you....	Never	Rarely	Sometimes	Often	Almost Always
	0	1	2	3	4
have trouble getting things organized?	●	○	○	○	○
have trouble concentrating on things like watching a television program or reading a book?	●	○	○	○	○
forget the date unless you looked it up	●	○	○	○	○
forget what you talked about after a telephone conversation?	●	○	○	○	○
feel like your mind went totally blank?	●	○	○	○	○
Total for each column					
TOTAL SCORE (add your column scores)					

Cognitive Function: How difficult have these problems made it for you to do your work/take care of things at home or get along with other people?

● **Not difficult at all** ○ **Some-what difficult** ○ **Very difficult** ○ **Extremely difficult**

Section 12: ASEX—Male

Arizona Sexual Experiences Scale

For each item, please indicate your OVERALL level during the PAST WEEK, including TODAY.

	1	2	3	4	5	6
1. How strong is your sex drive?	●	○	○	○	○	○
	extremely strong	very strong	somewhat strong	somewhat weak	very weak	no sex drive
2. How easily are you sexually aroused (turned on)?	●	○	○	○	○	○
	extremely easily	very easily	somewhat easily	somewhat difficult	very difficult	never aroused
3. Can you easily get and keep an erection?	●	○	○	○	○	○
	extremely easily	very easily	somewhat easily	somewhat difficult	very difficult	never
4. How easily can you reach an orgasm?	●	○	○	○	○	○
	extremely easily	very easily	somewhat easily	somewhat difficult	very difficult	never reach orgasm
5. Are your orgasms satisfying?	●	○	○	○	○	○
	extremely satisfying	very satisfying	somewhat satisfying	somewhat unsatisfying	very unsatisfying	can't reach orgasm

Comments

Feel free to describe anything related to the questions or your answers

Section 13: Generalized Anxiety Disorder (Gad-7)

Guide for Interpreting GAD-7 Scores

1. Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several Days	Over Half the Days	Nearly Every Day
	0	1	2	3
Feeling nervous, anxious or on edge	●	○	○	○
Not being able to stop or control worrying	●	○	○	○
Worrying too much about different things	●	○	○	○
Trouble relaxing	●	○	○	○
Being so restless that it's hard to sit still	●	○	○	○
Becoming easily annoyed or irritable	●	○	○	○
Feeling afraid as if something awful might happen	●	○	○	○
Add the score for each column				
TOTAL SCORE (add your column scores)				

	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
	0	1	2	3
2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	●	○	○	○

Scale: **0-9** Mild | **10-14** Moderate | **15-21** Severe

GAD-7 developed by Dr. Robert L. Spiter, Dr. K. Kroenke, et al

Section 14: Penn State Worry Questionnaire (PSWQ)

Measure of Worry Phenomena

Indicate which number best describes how typical or characteristic each item is to you.

		None	Mild	Moderate	Severe	Extreme
1	If I don't have enough time to do everything I don't worry about it	●	○	○	○	○
2	My worries overwhelm me	●	○	○	○	○
3	I don't tend to worry about things	●	○	○	○	○
4	Many situations make me worry	●	○	○	○	○
5	I know I shouldn't worry about things, but I can't help it	●	○	○	○	○
6	When I am under pressure I worry a lot	●	○	○	○	○
7	I am always worried about something	●	○	○	○	○
8	I find it easy to dismiss worrisome thoughts	●	○	○	○	○
9	As soon as I finish one task, I start to worry about everything else I have to do	●	○	○	○	○
10	I never worry about anything	●	○	○	○	○
11	Whenever there is nothing more I can do about a concern, I don't worry about it anymore	●	○	○	○	○
12	I've been a worrier all my life	●	○	○	○	○
13	I notice that I have been worrying about things	●	○	○	○	○
14	Once I start worrying I can't stop	●	○	○	○	○
15	I worry all the time	●	○	○	○	○
16	I worry about projects until they get done	●	○	○	○	○

Section 15: ASRS-v1.1 Symptom Checklist

Adult Adhd Self-Report Scale

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. Mark the appropriate answer that best describes how you have felt and conducted yourself ***over the past 6 months***.

		Never	Rarely	Sometimes	Often	Very Often
1	How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?	●	○	○	○	○
2	How often do you have difficulty getting things in order when you have to do a task that requires organization?	●	○	○	○	○
3	How often do you have problems remembering appointments or obligations?	●	○	○	○	○
4	When you have a task that requires a lot of thought, how often do you avoid or delay getting started?	●	○	○	○	○
5	How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?	●	○	○	○	○
6	How often do you feel overly active and compelled to do things, like you were driven by a motor?	●	○	○	○	○
7	How often do you make careless mistakes when you have to work on a boring or difficult project?	●	○	○	○	○
8	How often do you have difficulty keeping your attention when you are doing boring or repetitive work?	●	○	○	○	○
9	How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?	●	○	○	○	○
10	How often do you misplace or have difficulty finding things at home or at work?	●	○	○	○	○
11	How often are you distracted by activity or noise around you?	●	○	○	○	○
12	How often do you leave your seat in meetings or other situations in which you are expected to remain seated?	●	○	○	○	○
13	How often do you feel restless or fidgety?	●	○	○	○	○
14	How often do you have difficulty unwinding and relaxing when you have time to yourself?	●	○	○	○	○
15	How often do you find yourself talking too much when you are in social situations?	●	○	○	○	○
16	When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?	●	○	○	○	○
17	How often do you have difficulty waiting your turn in situations when turn taking is required?	●	○	○	○	○
18	How often do you interrupt others when they are busy?	●	○	○	○	○

CHOKKA CENTER
FOR INTEGRATIVE HEALTH

CH003P

Submit Questionnaire

Thank you for completing the questionnaire. There are (3) ways to submit the completed form:

1. Save the PDF using the following naming convention and send to us via email to become@chokkacenter.com

FIRSTNAME_LASTNAME_Diagnostic_MO_YR.pdf

2. Use the submit button below. This will automatically send your completed questionnaire to us. We will send a receipt of conformation once received.

SUBMIT

3. Scan and fax to: 780-465-5799