Chicago Psychiatry Associates'

Program in Psychiatric Chronotherapy

in collaboration with
The Center for Environmental Therapeutics

Screening Questionnaire

Thank you for your interest in our Program in Psychiatric Chronotherapy. In order to best address your specific treatment needs please fill out this form as completely as possible and fax to 312-782-5960 or scan and email as an attachment to chronotherapy@chicagopsychiatryassociates.org. We will contact you within one to two business days of receiving your questionnaire.

Date: _____

Name: _____

Address: _____

City, State, Zip Code: _____

Preferred Phone Number: _____

May we leave a message at the above number? YES or NO

Email Address: _____

DOB: _____ **Sex: M / F**

How did you hear about our Program for Psychiatric Chronotherapy?

_____

Are you currently in treatment for depression? YES or NO

If yes, would you please provide the name and phone number of your psychiatrist:

_____

If yes, would you please provide the name and phone number of your psychologist or therapist:

_____

For those individuals who are currently in psychiatric or psychotherapeutic treatment, we require the consent of your clinician to participate in our program.

Have you discussed participation in our program with your psychiatrist?

YES or NO

Have you discussed participation in our program with your psychologist or therapist?

YES or NO

If you answer no to either of the prior two questions, we respectfully request that you first discuss our treatment program with your current clinician before completing and returning this questionnaire. Your clinician's awareness of and support for a chronotherapeutic consultation is an essential part of our treatment process.

If we proceed with a consultation and assessment, would you agree to let us speak with your psychiatrist/clinician for the purposes of diagnosis and treatment coordination?

YES or NO

If yes, you will need to provide authorization to your psychiatrist/clinician to allow them to speak with us.

Psychiatric History and Treatment History

If you have been diagnosed with or treated for any of the following conditions within the last 5 years please check the corresponding box and explain treatments or medications on the corresponding line:

□ Major Depressive Disorder _____
□ Bipolar Disorder _____
□ Cyclothymic Disorder _____
□ Panic Disorder _____
□ Obsessive Compulsive Disorder _____
□ Posttraumatic Stress Disorder _____
□ Psychotic Disorder:
***specify*_____** _____
□ Bulimia or anorexia nervosa _____
□ Phobias: *specify* _____ _____
□ Memory disorder, dementia or Alzheimer's Disease _____
□ Seasonal Affective Disorder _____
□ Dysthymic Disorder _____

□ **Anxiety Disorder** _____

□ **Sleep Disorder:**
*specify*_____ _____

□ **Attention Deficit Hyperactivity Disorder** _____

□ **Schizophrenia/ Schizoaffective Disorder** _____

□ **Substance abuse or dependency** _____

□ **Borderline Personality Disorder** _____

□ **Other Personality Disorder:**
*specify*_____ _____

□ **Dissociative Disorder:**
specify _____ _____

Have you ever or are you currently experiencing psychotic symptoms such as hallucinations, delusions, paranoia, disordered thinking, etc? YES or NO

Have you ever been diagnosed as having treatment-resistant depression? YES or NO

Medical History and Treatment History

If you have been diagnosed with or treated for any of the following conditions within the last 5 years please check the corresponding box and list all treatments or medications on the corresponding line:

□ **Diabetes** _____

□ **Diabetes related eye problems** _____

□ **Lupus or other Autoimmune Disorder** _____

□ **Thyroid/ Circle: *high or low*** _____

□ **Seizure Disorder** _____

□ **Other Neurologic Disorder:**
type _____ _____

□ **Parkinson's Disease** _____

□ **Migraines** _____

□ **Cancer: *type*** _____ _____

□ **Chronic Infections** _____

□ **HIV infection or AIDS** _____

□ **Chronic Fatigue Syndrome** _____

□ **Heart Disease** _____

□ **Other:** _____ _____

□ **Other:** _____ _____

□ **Cataracts/ Circle: *current or lens replacement*** _____

□ **Retinal Detachment** _____

□ **Retinitis Pigmentosa** _____
□ **Macular Degeneration** _____
□ **Retinitis Pigmentosa** _____

Do you use any other medications or supplements not described above? If so, please indicate with doses and frequency.

_____
_____
_____

Are you pregnant? YES or NO or NOT APPLICABLE

Have you ever been hospitalized for a psychiatric disorder? YES or NO

If yes, please describe including dates and treatment:

_____
_____

Have you found any past or current treatments to be helpful? YES or NO

If yes, please describe:

_____
_____

Have you used light therapy before? If so, please describe how you used it, what apparatus you used (manufacturer/ model), and how you responded:

_____
_____
_____

What was the date of your last physical examination? _____

When was the date of your last eye examination? _____

Are you currently involved in litigation, a disability claim, or a worker's compensation case regarding your psychiatric disorder and/or treatment?
If yes please describe:

_____
_____
_____