Delta Family Clinic
Treatment you can trust!

DELTA FAMILY CLINIC SOUTH P.C.

Pre-Surgical Questionnaire

PATIENT NAME: _____ AGE: _____ SEX: M / F

ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ HOME PHONE: (_____)_____-_____ DATE OF BIRTH: ____/____/_____

1. Patient Occupation: _____
2. Referred by Dr. _____ from the _____ Office/Surgery Center.
3. How long have you experienced significant pain? _____
4. How long have you been seriously impaired by your pain? _____
5. How have you been treating your pain? _____
6. What is your current motivation for seeking surgery? _____

   _____
7. Have you ever seen a mental health therapist or counselor before? Yes / No . If you circled yes, please include when? _____ and for? _____
8. Have you ever taken an anti-depressant medication? Yes / No If yes, please include which medication(s)? _____, and for how long? _____
9. Have you ever attempted suicide? Yes / No When? _____
10. Have you ever diagnosed with substance abuse disorder? Yes / No
11. My current intake of alcohol over the past year is _____ alcoholic beverages per week/month/year.
12. Over the past year, I have use the following recreational drugs: _____

    _____ every week/month/year.
13. I have participated in _____ prior psychological testing(s) or evaluations for _____ on the following date _____.
14. Have you ever been diagnosed with any of the following?

Severe Depression	Yes / No
Bipolar or Manic-Depressive Disorder	Yes / No
Impulse Control or Obsessive-Compulsive Disorders	Yes / No
Addictive Behaviors	Yes / No
Schizophrenia	Yes / No

15. Have there been any of the following kinds of difficulties with any of your blood relatives?

Severe temper tantrums or mood problems?	Yes / No
Mental illness?	Yes / No
Problems with alcohol or drug use?	Yes / No
Physical or sexual abuse?	Yes / No
Criminal Behaviors?	Yes / No

Briefly explain any yes answers to the above questions: _____

_____

_____ _____ _____ _____

Patient Signature Date Clinician Signature Date