Virginia Mason Franciscan Health

New Patient Visit

Name: _____

Date of birth: _____

Preferred Name: _____ (Optional) Gender pronoun(s) _____

Concern(s) you wish to discuss today:

_____

Which medication(s) do you need refilled?

_____

What is your preferred pharmacy and location?

_____

Do you think of yourself as ☐ Heterosexual/straight ☐ Homosexual/lesbian/gay ☐ Bisexual
☐ Choose not to disclose ☐ Don't know ☐ Something else _____

Mood

Do you have a history of depression or are you being treated for depression? ☐ No ☐ Yes

PHQ-9 **Over the last 2 weeks, how often have you been bothered by any of the following problems?**	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling asleep or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite/overeating	0	1	2	3
6. Feeling bad about yourself or that you are a failure or have let yourself/family down	0	1	2	3
7. Trouble concentrating, i.e., reading newspaper, watching TV	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or thoughts of hurting yourself in some way	0	1	2	3
PHQ-9 TOTAL	0	0	0	0

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 ☐ Somewhat Difficult ☐ Very Difficult ☐ Extremely Difficult

Patient Name & ID#

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GAD-7 **Over the last 2 weeks, how often have you been bothered by the following problems?**	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
GAD-7 TOTAL	0	0	0	0

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 ☐ Somewhat Difficult ☐ Very Difficult ☐ Extremely Difficult

If you enroll in MyVM, online benefits include ability to view your visit notes and tests, as well as to self-schedule appointments and send brief non urgent messages to your provider's team.

☐ I wish to enroll in MyVM. My preferred email address is: _____

☐ I prefer not to enroll in MyVM. Please let us know if you would like a printed copy of your note

☐ I am already enrolled in MyVM

Thank you for completing this form. If you are completing this online, please download and save a copy.

If you are enrolled in MyVm, please attach in a MyVM message to your provider's team.

Your clinical visit note will be available in MyVM for review after the visit as well.

If you are not enrolled in MyVM, please print your form, and bring to your visit.

Patient Name & ID#

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