

Questionnaire

What leads you to seeking treatment at this time? Is there something specific, such as a particular event? Be as detailed as you can.

What are your goals for psychiatric treatment?

Have you seen a mental health professional before?

- Yes
- No

Who is your current therapist, including phone number?

Who is your primary care physician? Please include type of MD, name and phone number.

If taking medication, please list them along with the dosage and frequency

If taking prescription medication, who is your prescribing MD? Please include type of MD, name and phone number.

What medications have you tried in the past? Please list names and doses if you recall.

Current pharmacy with address and phone number?

Do you have medical problems that are treated by a physician or for which you are on medication?

Have you had surgeries? Please list them.

Do you drink alcohol?

- Yes
- No

Do you use recreational drugs? This includes marijuana, cocaine, opioids, MDMA (ecstasy), hallucinogens, PCP, and other illicit substances.

- Yes
- No

Do you have suicidal thoughts?

- Yes
- No

Have you ever attempted suicide?

- Yes
- No

Do you have thoughts or urges to harm others?

- Yes
- No

Have you ever been hospitalized for a psychiatric issue?

- Yes
- No

Is there a history of mental illness in your family?

- Yes
- No

If you are in a relationship, please describe the nature of the relationship and months or years together.

Describe your current living situation. Do you live alone, with others. With family, etc...

What is your level of education? Highest grade/degree and type of degree.

What is your current occupation? What do you do? How long have you been doing it?

Please check any of the following you have experienced in the past six months

- Increased appetite
- Decreased appetite
- Trouble concentrating
- Difficulty sleeping
- Excessive sleep
- Low motivation
- Isolation from others
- Fatigue/low energy
- Low self-esteem
- Depressed mood
- Tearful or crying spells
- Anxiety
- Fear
- Hopelessness
- Panic
- Other

Please check any of the following that apply

- Headache
- High blood pressure
- Gastritis or esophagitis
- Hormone-related problems
- Head injury
- Angina or chest pain
- Irritable bowel
- Chronic pain
- Loss of consciousness
- Heart attack
- Bone or joint problems
- Seizures
- Kidney-related issues
- Chronic fatigue
- Dizziness
- Faintness
- Heart valve problems
- Urinary tract problems
- Fibromyalgia
- Numbness & tingling
- Shortness of breath
- Diabetes
- Hepatitis
- Asthma
- Arthritis
- Thyroid issues
- HIV/AIDS
- Cancer
- Other

What else would you like me to know?