

PATIENT QUESTIONNAIRE

Name: _____

Date: _____

Date of Birth: _____

If you do not have enough room to answer a question, continue on the back of this form or another piece of paper.

A. PSYCHIATRIC HISTORY

1. Have you ever seen a mental health provider for any reason (this includes psychiatrist, psychologist, counselor, etc.)? If yes, when, why, and how many visits?

2. Have you ever been hospitalized for psychiatric reasons? If yes, when, why, and how long?

3. Please list all medications you are taking, including over-the-counter medications.

4. Have you ever made a suicide attempt or thought about suicide? If yes, give details.
Yes No

5. Have you ever hurt someone else physically? If yes, give details. Yes No

B. FAMILY HISTORY

Has anyone in your family had any emotional or psychological problems? Of yes, what is their relationship to you: mother, aunt, paternal cousin, etc. and what was the problem?
Yes No

C: SYMPTOMS SCREEN If yes, give details

1. Have you ever been sad or depressed for more than two weeks? Yes No

2. Have you ever had so much energy that you did not need to sleep and you made big plans or bad decisions? Yes No

3. Have you ever been so anxious that you could not do anything or even leave the house?
Yes No

4. Do you often feel that you need to count, check, or clean things in a special way?
Yes No

5. Do you ever have several minutes of extreme anxiety and fear that comes out of the blue?
Yes No

6. Do you ever feel that you cannot control your thoughts or that people can read or control your mind? Yes No

7. Have you ever thought about someone so much that you followed them? Yes No

8. Have you ever heard noises or voices that others could not hear? Yes No

9. Have you ever seen things that others could not see? Yes No

D. CHILDHOOD HISTORY

1. Where were you born and reared and whom did you live with while growing up?

2. To your knowledge, did you develop normally as a child (physically and mentally)?
If no, explain. Yes No

3. Did you have any problems in school, such as discipline or conduct problems?
If yes, explain. Yes No

4. Any legal problems as a child? If yes, explain. Yes No

5. Have you ever run away from home? If yes, explain. Yes No

5. Did you ever do or have any of the following: If yes, how old and why?

set fires for fun?	Yes	No
skip school?	Yes	No
hurt animals?	Yes	No
get expelled or suspended?	Yes	No
have a learning disability?	Yes	No
have few friends?	Yes	No
repeat a grade?	Yes	No

7. Did you have any difficulties with wetting the bed or going to the bathroom in your pants?
If yes, explain. Yes No

8. List the schools you attended and when, beginning with elementary school.

EDUCATION (beginning with elementary school)		
Dates Attended	School, city & state	Degree obtained (If applicable)

E. WORK HISTORY

WORK HISTORY		
List jobs since graduating high school. If you went to college right after high school, begin after college. If you run out of room, continue on the back or another sheet of paper.		
DATE or Age	Company and position	Why did you leave?

1. Which of the above was your favorite job?
2. How do you currently support yourself and family?
3. Have you ever served in the military? Yes No
What was your rank and what type of discharge did you have?

F. SUBSTANCE ABUSE AND TRAUMA

1. What street or illicit drugs have you used and when? How much alcohol do you drink?
2. Have you ever been physically or sexually abused? If yes, when, by whom? Yes No
3. Have you seen someone seriously hurt, abused, or raped? Yes No (If yes, explain)

