ADULT PSYCHIATRIC QUESTIONNAIRE

Developed by
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Dear Patients: Please carefully fill in this form prior to your first appointment in order to help us reduce the time and cost of gathering this information at our office. We appreciate your cooperation and patience.

Patient's Name: _____

Date of Birth: ____/____/____ *Patient's Birthplace:*_____ *Sex:* ❑M ❑F

Race: ❑ African-American ❑ Caucasian ❑ Hispanic ❑ Asian ❑ Other _____

● Who referred you to our practice? _____

● Please briefly describe the problems for which you are seeking help at this time.

_____

_____

_____

_____

_____

_____

_____

_____

_____

● Approximately when did the problem(s) begin? _____

_____

● Any known stress cause or contribute to the problem(s)? ❑**No** ❑**Yes** *If Yes, please describe stress:*

_____

_____

● Have you ever received outpatient mental health treatment? ❑ **No** ❑ **Yes**

If yes, please list in order, including Psychological or IQ/School testing:

Clinician/ Doctor	Date(s) of Evaluation or Treatment	Type of Evaluation or Treatment	Frequency of visits

● Have you ever received inpatient mental health treatment? ❑ **No** ❑ **Yes**
If yes, please list in order:

Hospital Name	Dates of Treatment	Reason for hospitalization

● If you have ever taken psychiatric medications, please list them below: ❑ **Not applicable**

Rx Name	Reason Given	Highest Dose	% Improvement	Side-effects	Dates Taken

● Have you ever threatened or attempted suicide? ❑ **No** ❑ **Yes** If yes, please describe:

_____

_____

● Have you ever had any brain imaging or functional studies? ❑ **No** ❑ **Yes**
(MRI, CAT scan, EEG, etc.)

Substance Use History:

● Please describe your past or current use of any of the following substances: ❑ **Never tried any**

Substance	Age at 1st use	Frequency of use	Amount used	Last use	**Problems** (physical, legal, occupation, relationships, etc.)
ALCOHOL					
TOBACCO					
MARIJUANA					
COCAINE					
AMPHETAMINE					
ECSTACY					
LSD/ ACID					
OPIATES					
INHALANTS					
HALLUCINOGENS (mushrooms, PCP, etc)					

● Have you ever received inpatient or outpatient substance abuse treatment? ❑ **No** ❑ **Yes** *If yes, please list:*

Hospital/ Doctor Name	Dates of Treatment	Detox, Rehab, or AA/NA?

Family Psychiatric History:

(Please note ADHD, Learning Disorders, Depression, Bipolar Disorder, Anxiety Disorders, Obsessive-Compulsive Disorder, Tic/ Tourette's, Schizophrenia, Drug or Alcohol Abuse, Suicide attempts, or other Psychiatric Problems).

- Are you adopted?……..……❑ **No** ❑ **Yes**

  *If Yes, Please describe the circumstances of the adoption:*_____

- Is there a history of ADHD, mental illness, mental retardation, learning problems, alcohol or drug abuse in your grandparents, parents, siblings, or 1st cousins?……❑ **No** ❑ **Yes**

  If Yes, please fill in the following chart:

Affected Family Member	Type of Mental Illness or SA	Treatment (if any)

Childhood Development:

- ***Pregnancy---***Please check any that apply to your mother's pregnancy with you:

❑ Received prenatal care
❑ Smoked during pregnancy
❑ Took medications
❑ Diabetes of pregnancy
❑ Premature labor
❑ Nausea or Vomiting
❑ Severe Emotional Distress
❑ Drank alcohol during pregnancy
❑ Used drugs during pregnancy
❑ Elevated blood pressure
❑ Pre-eclampsia
❑ Threatened miscarriage
❑ Infection(s)

- ***Birth History:***

Mother's age at time of birth: _____ years old. Father's age at time of birth: _____ years old.

Was mother given medication or anesthesia?…….❑ **Don't know** ❑ **No** ❑ **Yes**

Delivery was: .....❑ **Spontaneous Vaginal** ❑ **Induced** ❑ **Caesarian section**

Any complications with labor or delivery?…….…… ❑ **No** ❑ **Yes** _____

Were you premature? ……. ❑ **No** ❑ **Yes** _____

Your birthweight: _____lbs _____oz

Did you have any of the following:

Breathing problems……..	❑ **No**	❑ **Yes**
Cord around the neck……	❑ **No**	❑ **Yes**
Abnormal color ……	❑ **No**	❑ **Yes**
Abnormal tone ……..……	❑ **No**	❑ **Yes**
Meconium ……..…….	❑ **No**	❑ **Yes**
Failure to thrive …….	❑ **No**	❑ **Yes**
Jaundice ……	❑ **No**	❑ **Yes**
Infection ……	❑ **No**	❑ **Yes**

- ***Developmental Milestones*** *(answer as best you can recall)*

Motor Development (sitting, crawling, walking)…….	❑ **Normal**	❑ **Fast**	❑ **Slow**
Speech & Language …….	❑ **Normal**	❑ **Fast**	❑ **Slow**
Self-help skills (dressing, brushing, toileting, hygiene) …….	❑ **Normal**	❑ **Fast**	❑ **Slow**

● ***Childhood Home:***

Primary Residence as a child: ❑ Single parent home ❑ Two parent home ❑Other_____

Check all that describe your home environment as a child:

❑ Nurturing	❑ Loving	❑ Supportive
❑ Abusive	❑ Critical	❑ Stressful
❑ Rigid	❑ Harsh discipline	❑ Little discipline

Other applicable information: _____

_____

Medical History:

● Who is your Internist or Family Doctor? _____

● When was your last physical examination? _____

● Current Medications *(include Over-the-counter meds, Vitamins, Herbs, or Supplements)*

❑ **None** OR *Please List*:

Rx Name	Dosage	Frequency	Prescribing M.D.

● Do you have any drug allergies? ……❑ **No** ❑ **Yes** *(please list):*

_____

● Do you have any current medical problems? ……❑ **No** ❑ **Yes** *(please list):*

_____

● Please check & briefly describe if you have experienced any of the following conditions:

❑ Surgeries _____

❑ Chest pain	❑ Significant accidents or injuries
❑ Abnormal heart rate or rhythm	❑ Heart attack
❑ High Blood Pressure	❑ Stroke
❑ Seizures/Convulsions	❑ Cancer
❑ Diabetes	❑ Acid Reflux
❑ Head injury	❑ Kidney/ Bladder problems
❑ Arthritis/ Joint problems	❑ Fainting/ Dizziness
❑ Frequent Headaches	❑Allergy/ Sinus problems
❑ Thyroid disease	❑ High cholesterol
❑ Vision problems	❑ Sexual problems

Social History:

● City of Residence: _____

● Now Living with: ❑ **Spouse** ❑ **Children** ❑ **Roommate** ❑**Other:**_____

● Children in family: ❑ **N/A** OR

Names & Ages: _____ _____ _____ _____

● Marital status: ❑ Single ❑ Separated ❑ Divorced ❑ Married (*How long*?)_____

● Have you ever experienced or witnessed any physical abuse, sexual abuse, or neglect?
❑ **No** ❑ **Yes**

If Yes, please briefly describe: _____

Job History:

Please list all previous & current full-time employment:

Position/ Job	Name of Employer	Dates of employment	Reason for leaving job

If currently employed, do you find satisfaction in your work? ❑ **No** ❑ **Yes**

School History:

● Highest grade level completed: _____ Name of last school attended: _____

Current Academic Performance: ……. ❑ **Good** ❑ **Fair** ❑ **Poor** ❑ **N/A**
Past Academic Performance: ……... ❑ **Good** ❑ **Fair** ❑ **Poor**
Past Behavioral Performance: ……. ❑ **Good** ❑ **Fair** ❑ **Poor**

● Were you ever in any special education programs? …….❑ **No** ❑ **Yes** (*explain*):

_____

● Any known Learning Disabilities? …… … ❑ **No** ❑ **Yes**

Legal Problems:

● Have you ever been arrested or had legal charges?……... ❑ **No** ❑ **Yes** *(explain):*

_____

Religious Beliefs:

❑ None ❑ Jewish ❑ Muslim ❑ Hindu ❑ Other _____

❑ Christian (*list denomination*) _____

Actively involved in local church?…… …… ❑ **No** ❑ **Yes**

Pray regularly? ……... ❑ **No** ❑ **Yes**

In your home, the practice of your faith is: ❑ **Not important** ❑ **Somewhat important** ❑ **Very Important**

Thank You!!!