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Psychiatric and Medical History Questionnaire

Kindly take a moment to fill out this form before your visit. Although it may seem like a lot, most questions only require you to check the appropriate box.

Name: _____ Date: _____ Date of Birth: _____

Primary Care Physician: _____ Phone: _____

Current Therapist/Counselor: _____ Phone: _____

What are the problem(s) for which you are seeking help?

1. _____

2. _____

What are your treatment goals?

_____

_____

Past Medical History:

Medication Allergies: ☐ Yes ☐ No What Medications: _____

List **ALL** current prescription medications and how often you take them: (if none, write none)

Medication Name	Daily Dose	Frequency	Estimated Start Date

Over-the-counter medications or supplements: _____

Current medical problems: _____

Past medical problems, non-psychiatric hospitalization, or surgeries: _____

_____

Do you have any concerns about your physical health that you would like to discuss with us? ☐ Yes ☐ No

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General Health Review

In the **PAST 14 DAYS** have you experienced any of the following: (**circle ALL that apply**)

Constitutional: unexplained weight change, fevers, chills, night sweats, fatigue, appetite change

Eyes: vision changes, eye pain, blurred vision, double vision

Ears, Nose, Throat: hearing change, ringing in your ears, sore throat, sinus pain, ear pain, difficulty swallowing

Heart: chest pain, shortness of breath, palpitations, exercise intolerance, leg pain with walking

Lungs: cough, wheezing, asthma, coughing up blood

Abdomen: pain, nausea, vomiting, diarrhea, bloody stool, constipation, cramping, excess gas, dark black stool

Urinary: pain, difficulty urinating, bloody urine, excessive urination, discharge, change in smell/taste, imbalance

Musculoskeletal: pain, swelling, decreased movement, stiffness, dislocating joints, arthritis

Skin: itching, rashes, discoloration, skin cancer, non-healing wounds, eczema

Neurologic: headache, seizure, numbness, tingling in your extremities, tremors

Endocrine: thyroid disorder, reproductive disorders, hot/cold intolerance, thinning hair, excessive thirst

Blood: easy bruising, blood disorders, anemia, blood clots, excessive bleeding

Immune: allergies, anaphylaxis, swollen lymph nodes,

Female Patients only:

Date of last menstrual period: _____Birth control method _____

Are you currently pregnant or planning to get pregnant? ☐ Yes ☐ No

How many times have you been pregnant? _____How many live births? _____

Personal Medical History:

Do you have a personal history of any of the following medical conditions?

Hypothyroid	☐ Yes	☐ No	Fibromyalgia	☐ Yes	☐ No
Hyperthyroid	☐ Yes	☐ No	Cancer (Type: _____)	☐ Yes	☐ No
Liver Disease	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No
Kidney Disease	☐ Yes	☐ No	Anemia	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Chronic Pain	☐ Yes	☐ No
Asthma/respiratory problems	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No
COPD	☐ Yes	☐ No	High blood pressure	☐ Yes	☐ No
IBS/Crohn's/GI concerns	☐ Yes	☐ No	Head trauma	☐ Yes	☐ No

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Substance Use

Have you ever been treated for alcohol or drug use or abuse? ☐ Yes ☐ No

If yes, for which substances? _____

How many days per week do you drink any alcohol? _____

How many drinks do you have on a typical day? _____

In the past three months, how many alcoholic drinks you have consumed in one day? _____

Have you ever felt you should cut down on your drinking or drug use? ☐ Yes ☐ No

Have people annoyed you by criticizing your drinking or drug use? ☐ Yes ☐ No

Have you ever felt bad or guilty about your drinking or drug use? ☐ Yes ☐ No

Have you ever had a drink first thing in the morning to steady your nerves? (Eye-opener) ☐ Yes ☐ No

Do you think you may have a problem with alcohol or drug use? ☐ Yes ☐ No

Have you used any drugs or medication not prescribed to you in the past 3 months? ☐ Yes ☐ No

If yes, please explain: _____

Have you ever abused prescription medication? ☐ Yes ☐ No

If yes, please explain: _____

Have ever tried or experimented with any of the following:

Methamphetamine	☐ Yes	☐ No	Bath salts	☐ Yes	☐ No
Cocaine	☐ Yes	☐ No	Opioids	☐ Yes	☐ No
Stimulants (pills)	☐ Yes	☐ No	Pain killers (not as prescribed)	☐ Yes	☐ No
Heroin	☐ Yes	☐ No	Methadone	☐ Yes	☐ No
LSD or Hallucinogens	☐ Yes	☐ No	Tranquilizer/sleeping pills	☐ Yes	☐ No
Marijuana	☐ Yes	☐ No	Ecstasy	☐ Yes	☐ No

Have you ever smoked cigarettes? ☐ Yes ☐ No

Do you currently smoke? ☐ Yes ☐ No

How many packs per day on average? _____ How many years? _____

In the past? ☐ Yes ☐ No

How many years did you smoke? _____ When did you quit? _____

Pipe, cigars, or chewing tobacco: Currently? ☐ Yes ☐ No In the past? ☐ Yes ☐ No

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Past Psychiatric History

Have you been under the care of a mental health provider previously? ☐ Yes ☐ No

Have you ever been hospitalized for psychiatric care? ☐ Yes ☐ No

If yes to the above, please complete the information below to the best of your recollection.

Dates	Diagnosis	Treatment type	Provider

Past Psychiatric Medications

Please list any previous psychiatry medications that you have been prescribed

Medication	Highest Dose	Dates	Response	Any side effects?

Family Psychiatric History

Has anyone in your family been diagnosed with or treated for:

Bipolar disorder	☐ Yes	☐ No	Alcohol abuse	☐ Yes	☐ No
Schizophrenia	☐ Yes	☐ No	Anger	☐ Yes	☐ No
Depression	☐ Yes	☐ No	Suicide	☐ Yes	☐ No
Post-traumatic stress	☐ Yes	☐ No	Violence	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No			

Family Medical History

Please list medical conditions such as diabetes, cancer, heart disease, etc. for immediate **family members** including *mother, father, brothers, sisters, or children*.

Medical Condition	Family Member Relationship

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Family Background and Childhood History

Were you adopted? ☐ Yes ☐ No Where did you grow up? _____

List your siblings and their ages: _____

_____

Did your parents' divorce? ☐ Yes ☐ No If so, how old were you when they divorced? _____

If your parents divorced, who did you live with? _____

Trauma History

Do you have a history of being abused emotionally, sexually, physically or by neglect? ☐ Yes ☐ No

If yes, please explain: _____

_____

Have you ever been diagnosed with a traumatic brain injury? ☐ Yes ☐ No

Educational History

Highest Grade Completed? _____Where? _____Did you graduate? _____

Did you attend college? _____Where? _____Major? _____

What is your highest educational level or degree attained? _____

Occupational History

Are you currently: ☐ Working ☐ Student ☐ Homemaker ☐ Unemployed ☐ Disabled ☐ Retired

What is/was your occupation? _____How long in present position? _____

Where do you work? _____

Have you ever served in the military? ☐ Yes ☐ No What branch and when? _____

Honorable discharge ☐ Yes ☐ No If no, what type of discharge _____

Relationship History and Current Family

Are you currently: ☐ Married ☐ Partnered ☐ Divorced ☐ Single ☐ Widowed

If you are married/partnered, how long? _____

Are you sexually active? ☐ Yes ☐ No

How do you identify your gender?

☐ Male ☐ Female ☐ Transgender (M / F) ☐ non-binary ☐ Other: _____

How do you identify your sexual orientation?

☐ straight/heterosexual ☐ unsure/questioning ☐ prefer not to answer

☐ lesbian/gay/homosexual ☐ asexual

☐ bisexual ☐ other: _____

What is your spouse/partner/significant other's occupation? _____

How would you describe your relationship? _____

_____

Have you had any prior marriages? ☐ Yes ☐ No If so, how many? _____How long? _____

Do you have children? ☐ Yes ☐ No

If yes, list ages and gender: _____

Legal History

Have you ever been arrested? _____ Do you have any pending legal problems? _____

Spiritual Life

Do you belong to a particular religion or spiritual group? ☐ Yes ☐ No

If yes, what is the level of your involvement? _____

Do you find your involvement helpful during this illness or does the involvement make things more difficult or stressful for you? ☐ more helpful ☐ stressful

Suicide Risk Assessment

Have you ever had feelings or thoughts that you didn't want to live? ☐ Yes ☐ No

If YES, please answer the following. If NO, please skip to the next section.

Do you currently feel that you don't want to live? ☐ Yes ☐ No

Are you currently thinking about hurting yourself? ☐ Yes ☐ No

How often do you have these thoughts? ☐ constantly ☐ daily ☐ weekly ☐ infrequently

When was the last time you had thoughts of dying? _____

Has anything happened recently to make you feel this way? _____

On a scale of 1 to 10, (ten being strongest) how strong is your desire to kill yourself currently? _____

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Would anything make it better? _____

Have you ever thought about how you would kill yourself? ☐ Yes ☐ No

Please explain: _____

Have you planned a time for this? _____

Is there anything that would stop you from killing yourself? ☐ Yes ☐ No

Please explain: _____

Do you feel hopeless and/or worthless? ☐ Yes ☐ No

Please explain: _____

Have you ever tried to kill or harm yourself before? ☐ Yes ☐ No

Please explain: _____

Is there anything else that you would like us to know?

_____

_____

_____

_____

_____

_____

_____

Signature: _____ Date: _____