Today's Date:_____

New Patient Questionnaire

Patient Name:_____ Age:_____

Name of Person filling out form & Relationship to patient:_____

Who referred you to our office? _____

Current Psychiatric Symptoms - Circle all that apply:

Depressed or Sad Mood	Loss of interests	Feelings of Guilt	Withdrawal from others
Decrease in energy	Hopelessness	Worthlessness	Sleeping too much
Suicidal thoughts	Suicidal Plan	Past Suicide attempts	Self-Harm Behavior
Anger Issues	Irritability	Thoughts of or Harming others	Trouble falling/staying asleep
Racing Thoughts	Higher energy than usual	Rapid speech	Elevated mood
Anxiety	Worry/Tension/On edge	Panic Attacks	Obsessive Thoughts
Change in Appetite	Repetitive behaviors	Hearing Voices	Visual Hallucinations
Feeling paranoid	Having unreal thoughts	Memory problems	Issues with Attention & Focus/Easily Distracted

Other Psychiatric Symptoms (please list or describe):_____

_____

Are you currently seeing a therapist/counselor? If so, please provide name, phone/fax #, email:

_____

Have you ever received psychological, psychiatric or counseling services in the past?
If yes, please describe:

When?	From Whom?	For What?	With What Results?

Please list any previous psychiatric medications you have taken including dose, duration and results:

_____

_____

_____

Please list all prior psychiatric hospitalizations and day programs (if any) below:

Approximate Date	Length of Stay	Name of Hospital	Reason for Admission

Have you ever attempted to harm/kill yourself? If so, please list below:

Approximate date of attempt	How did you attempt (method)?

Regarding alcohol, when was your last drink?_____

In the past 30 days, about how many of those days have you had at least one alcoholic drink?_____

What is the maximum number of drinks you have had in one day in the past month? _____drinks

Have you ever had: DUI_____ DWI_____ Public Intoxication_____ Withdrawal symptoms_____

Substance Use - please circle any substances that you have used in the past or are currently using:

Benzodiazepines (Xanax, Valium, etc)	Tobacco, cigarettes, cigars	Hallucinogens (LSD (acid), mushrooms, mescaline, PCP or Angel Dust, Salvia)	Bath Salts
Cocaine	Marijuana	Ecstasy, MDMA	Inhalants
Amphetamine or speed	Tranquilizers	GHB	Diet Pills
Methamphetamine	Pain Pills, Opioids	Heroin	Laxatives
Anabolic Steroids	Sleeping Pills	IV Drug Use	Diuretics
K2/Spice	Caffeine	Other:	

Please list ***all* current medications** below including birth control pills, over-the-counter medications, herbal supplements and vitamins:

Medication name	Dosage (mg)	How many times a day?	How long you've been taking?	Side Effects (if any)	Prescribing Provider

Medical History: Do you have, or have you ever had any of the following? (please check all that apply)

	Mark √		Mark √		Mark √
High blood pressure		High Cholesterol		Bronchitis/Pneumonia	
Neurological Issues (stroke, brain tumor, nerve damage)		Gastrointestinal Issues (ulcers, pancreatitis, IBS, colitis, etc)		Urinary Tract or Kidney Problems (Stones, etc)	
Asthma		Eye or vision problems		Gall Bladder Problems	
Thyroid problem		Ear Infections/Hearing Loss		Liver Problems or Hepatitis	
Other Endocrine/Hormonal Problems		Head Injury/Traumatic Brain Injury		Sexually Transmitted Infections	
Heart problems, Murmur		Frequent Headaches/Migraines		Sickle Cell Anemia	
Diabetes		Sore throats		HIV+ or AIDS	
Seizures/Epilepsy		Sinus Infections		Tuberculosis	
Arthritis/Joint Problems		Persistent Cough		Cancer	
Chronic Pain		Allergies/Hay Fever		Lyme's Disease	
Fibromyalgia		Lung Disease		Lupus	
Anemia		Sleep Apnea		Skin Conditions	
Easy bruising or bleeding		Eating Disorder		Dizziness/Fainting	
Other:					

Please list any **Allergies** to medication or food:_____

_____

Please list any **Surgeries** or **Hospitalizations**:_____

_____

Primary Care Provider: Name, Phone & Fax#:_____

_____

For Female patients (if applicable):

Last menstrual period:_____ Contraceptive Method:_____

Family History: Has anyone in your family (parents, siblings, aunts/uncles, grandparents, children) ever been treated for any of the following?
(please check Yes for all that apply and indicate the family member's relationship to the patient)

	No	Yes	Relationship to patient
High Blood pressure			
High Cholesterol			
Heart Attacks/Heart disease			
Strokes			
Diabetes (Type 1 or 2)			
Cancer/Tumors			
Dementia/Alzheimer's			
Thyroid problems			
Other Medical Conditions:			
Depression			
Anxiety			
Panic Attacks			
Obsessive-Compulsive Disorder			
Bipolar/Manic Depression			
Schizophrenia			
Post-traumatic Stress			
Alcohol Problems			
Drug Problems			
ADHD			
Suicide attempts			
Psychiatric hospitalization			
Other Psychiatric disorders (Eating Disorders, Personality disorders, etc)			