Psychiatry Associates, P.C.
1736 Oxmoor Road. Suite 103
Birmingham, AL 35209
Telephone: 879 2120. Telecopier: 879 2125

PATIENT QUESTIONNAIRE

Full name _____ **Date:** _____

☐ Male; ☐Female Birthdate _____ Marital status _____ Age _____ Race _____

Address _____Home phone _____

Occupation _____ Mobile phone _____

Other significant contact_____ Phone _____

Referred by _____Relation _____

YOUR CURRENT CLINICAL PROBLEMS

List problems for which evaluation is sought: Length of time

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____
5. _____ _____
6. _____ _____

Impairment associated with current problems:

	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Work / School					
2. Social life					
3. Daily activities					

What have you tried so far to correct these problems (changes in life, psychotherapy, drugs)?

_____

_____

What specific event(s) caused you to seek help at this time? _____

_____

List **all clinicians** that have evaluated or treated you: ☐ None

Clinician	Reason	Type of treatment	Year and length
1.			
2.			
3.			
4.			

List **prescribed and non-prescribed medications** you are presently taking: ☐ None

Medication	Reason	Dosage	Length of treatment
1.			
2.			
3.			
4.			
5.			

YOUR PRESENT LIFE

Partner's or spouse's name _____ Years together _____

Age _____ Education _____ Occupation _____

General relationship with partner or spouse _____

Physical or emotional problems _____

List all persons living in the household with you:

Name	Age	Relationship	Education	Occupation
1.				
2.				
3.				
4.				
5.				

Please check all events that may have occurred within the past 12 months:

☐ Significant marital conflicts
☐ Separation
☐ Divorce
☐ Spouse with emotional difficulties
☐ Death of spouse
☐ Marriage
☐ Pregnancy
☐ Birth of child
☐ Gain of new family member
☐ Child leaving home

☐ Death of close family member
☐ Death of close friend
☐ Personal injury or illness
☐ Change in financial status
☐ Change in residence
☐ Significant conflicts at work
☐ Losing job
☐ Change in job
☐ Legal problems
☐ Other stress _____

Leisure and recreational activities _____

Religious affiliation and practice _____

Do you have any legal problems? ☐ No ☐ Yes. Explain _____

YOUR FAMILY

Mother's full name _____

Age _____ Education _____ Occupation _____

General relationship with mother _____

Health problems or cause of death _____

Father's full name _____

Age _____ Education _____ Occupation _____

General relationship with father _____

Health problems or cause of death _____

Brothers and sisters:

Name	Age	Education	Occupation	Relationship
1.				
2.				
3.				
4.				

Check if any <u>natural</u> parent, brother, sister, uncle, aunt, cousin or grandparent has:

☐ Attention deficit/hyperactivity disorder
☐ Learning disabilities
☐ Mental retardation
☐ "Blues", depressions
☐ Attempted suicide
☐ Bipolar/Manic depressive illness
☐ Problems with anxiety or panic attacks
☐ Addictions (alcohol, drugs, gambling, sex)
☐ Schizophrenia
☐ Other psychiatric problem
☐ Tics, seizures or neurological problems
☐ Legal problems

Please describe and indicate relation _____

_____

_____

YOUR LIFE STORY

Were there any problems with your mother's pregnancy or delivery of you? ☐ No ☐ Yes

Explain _____

Were you born full term? ☐ Yes ☐ No. Mother's age when you were born _____

Did you experience any separations from your parents as a child? ☐ No ☐ Yes. Explain _____

_____

What were you like as a child?

☐ Affectionate	☐ Very sensitive	☐ Irritable	☐ Moody
☐ Content	☐ Distractible	☐ Overly active	☐ Aggressive
☐ Fearful	☐ Playful	☐ Fussy / cranky	☐ Shy
☐ Physically sick	☐ Quiet	☐ Nervous	☐ Obedient

Have you ever experienced verbal / physical abuse? ☐ No ☐ Yes. Explain _____

_____

Have you ever experienced sexual abuse? ☐ No ☐ Yes. Explain _____

_____

What were you like during adolescence?

☐ Confident	☐ Shy	☐ Overly active	☐ Happy
☐ Sociable	☐ Aggressive	☐ Forgetful	☐ Defiant
☐ Irritable	☐ Peaceful	☐ Explosive	☐ Responsible
☐ Rebellious	☐ Depressed	☐ Unconventional	☐ Moody

List some good things about you. What can you do well? Special talents? _____

_____

How old were you when you first had sex? _____ How many sexual partners have you had? _____

Any sexual issues ? ☐ No ☐ Yes. Explain _____

_____

Have you been married more than once? ☐ No ☐ Yes. Explain _____

_____

_____

List all children residing away from home or deceased:

Name	Age	Education	Occupation	Relationship
1.				
2.				
3.				
4.				

YOUR PHYSICAL HEALTH AND HABITS

Your physician or family doctor _____ ___ Phone _____

Are you allergic to medication or anything? ☐ No ☐ Yes. Explain _____

_____

List all physical problems presently under treatment or observation: Length of time

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____

Do you have or had any of the following?

☐ Eye problems ☐ Staring spells ☐ Head trauma
☐ Hearing problems ☐ Seizures ☐ Asthma
☐ Speech problems ☐ Motor/vocal tics ☐ Liver disease
☐ Severe headaches ☐ Heart trouble ☐ Kidney problems
☐ Other medical problem. Explain _____

Have you ever been hospitalized? ☐ No ☐ Yes. Explain _____

_____

List surgical operations or injuries: Date occurred Any complications?

1. _____ _____ _____
2. _____ _____ _____
3. _____ _____ _____

Do you have or had any difficulty with drugs/alcohol? ☐ No ☐ Yes. Any DUI? ☐ No ☐ Yes

Explain _____

How much alcohol do you drink on average per week? _____

Is any of your friends/relatives concern about your using drugs/alcohol? ☐ No ☐ Yes. Why? _____

_____

How much caffeine do you consume on average per day? _____

How many cigarettes do you smoke per day? _____ How many years? _____

Only for females:

Age at first menstrual period _____ Date of last menstrual period _____

Are you on birth control? ☐ Yes ☐ No. Are the menstrual periods regular? ☐ Yes ☐ No

Explain _____

List of pregnancies and age _____

List of miscarriages / abortions and age _____

Any problems with pregnancies or deliveries? ☐ No ☐ Yes. Explain _____

YOUR EDUCATION AND JOB

Current occupation _____ Length _____

Educational degree _____ **Year completed** _____

Describe your school performance:

Grade level	Academics	Conduct
1. Elementary School		
2. Middle School		
3. High School		
4. College		

Did you pass each grade/year? ☐ Yes ☐ No. Explain _____

Were you ever enrolled in special services for

☐ Reading problems

☐ Mathematics problems

☐ Emotional/Behavioral problems

☐ Speech and language disorder

☐ None

Occupational and military history:

Employer	Type of job / position	Years of service
1.		
2.		
3.		

Have you ever been suspended or fired from work? ☐ No ☐ Yes. Explain _____

_____