

Patient name			
MHN	DOB	Age	Gender

## Psychiatric/MH Questionnaire

Appointment date (month/day/year) \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Therapist \_\_\_\_\_

**Answer these questions as completely as possible prior to attending your first appointment. Your responses will help us learn about your circumstances and assist you with individualized treatment for your problems.**

Street address \_\_\_\_\_ City or town \_\_\_\_\_

Telephone number: Work \_\_\_\_\_ Home \_\_\_\_\_

Do you have a preference where we contact you \_\_\_\_\_

Ethnicity:  White  African American  Native American  Hispanic  Asian  
 Middle Eastern  Other \_\_\_\_\_

Relationship status:  Married  Domestic partner  Single  Divorced  Separated  
 Widowed  Other \_\_\_\_\_

Employment status:  Employed full-time  Employed part-time  Unemployed  Disabled  
 Retired  Homemaker  Other \_\_\_\_\_

Do you have any special/disability needs we need to be aware of \_\_\_\_\_

Who referred you to us \_\_\_\_\_

Is it OK to send information to referral source or primary physician:  Yes  No

### Presenting problem/history of present problem

What problems do you need assistance with:  Depression  Anxiety  Relationship problem  
 Anger or irritability  Adjustment to major life change  Alcohol/Drug abuse  
 Coping with an illness or disability  Other (describe) \_\_\_\_\_

Briefly describe the history of your problem and what you have tried to do about it so far \_\_\_\_\_

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## Psychiatric/MH Questionnaire (Continued)

Patient name	MHN	DOB	Age	Gender
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### Psychiatric and/or AODA history

Do you currently have a psychiatrist, psychologist, social worker or counselor:  Yes  No

If yes, name(s) \_\_\_\_\_

List and describe all past treatment for psychological/psychiatric concerns or alcohol/drug problems:

Year	Doctor/Therapist	Inpatient/ Outpatient	Type of Treatment Name & Location of Treatment Facility <i>(Include medication, psychotherapy, counseling, alcohol or drug counseling, psychological testing, ECT, etc.)</i>

### Past medical history

Who is your personal physician \_\_\_\_\_ Last appointment \_\_\_\_\_

Describe surgeries, major illnesses, accidents or hospitalizations for medical problems:  None

Year	Where Treated	Type of Illness/Operation	Doctor/Therapist

Describe any current medical problems \_\_\_\_\_

Current Medication and Dose	Prescription	Non- prescription	How Often	What For

# Psychiatric/MH Questionnaire (Continued)

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List any allergies/reactions (plants, animals, medications) \_\_\_\_\_

	Tobacco	Caffeine	Alcohol	Street Drugs
Date last used				
Amount per day				
Tried to quit	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

## Family psychiatric history

Describe any family history of psychological difficulties, psychiatric illness, alcohol or drug abuse, history of violence or suicidal behavior:

- Psychiatric  
  Alcohol/Drug  
  Suicidal  
  Violent behavior

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## Social history

	Type of Work	Age or Date of Death	Physical Illness
Father			
Mother			
Brother/ Sister			
Spouse/ Partner			
Children/ Stepchildren			

# Psychiatric/MH Questionnaire (Continued)

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Any previous primary relationships/marriages:  Yes  No If yes, explain \_\_\_\_\_

What was your birth order and number of children in family (for example: oldest of 3, etc.) \_\_\_\_\_

Graduated from high school:  Yes  No If yes, what year \_\_\_\_\_

Education after high school:  Yes  No If yes, describe \_\_\_\_\_

Describe any school problems \_\_\_\_\_

Where are you employed \_\_\_\_\_

How long have you been there \_\_\_\_\_ Job title \_\_\_\_\_

Describe any job problems/concerns \_\_\_\_\_

Any legal or arrest history:  Yes  No Probation/Parole:  Yes  No

If yes, what type:  Traffic offenses  Alcohol/Drug  Property/Financial  Assault/Violence/Weapons

Any armed services history:  Yes  No If yes, how long \_\_\_\_\_ years

Discharge:  Honorable  Other Branch of service \_\_\_\_\_

Active religious practice:  Yes  No If yes, what religion \_\_\_\_\_

Who lives with you now in your household \_\_\_\_\_

Hobbies and leisure activities \_\_\_\_\_

Any other comments or concerns you want to share \_\_\_\_\_

\_\_\_\_\_  
Patient signature (Patient's legal representative) (Relationship) \_\_\_\_\_ /\_\_\_\_\_/\_\_\_\_\_  
Date (month/day/year)