Patient name			
MHN	DOB	Age	Gender

Adult

Psychiatric/MH Questionnaire

Appointment date (m/d/y) _____ /_____ /_____ Form completed by: ☐ Self ☐ Other (specify) _____

Your preference for how to best contact you _____

Ethnicity:
☐ White ☐ African American ☐ Native American ☐ Hispanic ☐ Asian ☐ Middle Eastern
☐ Other _____

Relationship status:
☐ Married ☐ Cohabitating ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Partnered
☐ Other _____

Employment status:
☐ Employed full-time ☐ Employed part-time ☐ Unemployed ☐ Disabled ☐ Retired
☐ Homemaker ☐ Other _____

Special or disability needs _____

Preferred language _____

Who referred you _____

Primary care provider _____

Problems you need assistance with:
☐ Depression ☐ Anxiety ☐ Adjustment to life change ☐ Relationship problems ☐ Anger/Irritability
☐ Alcohol/Drug abuse ☐ Coping with illness ☐ Other _____

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

_____

_____

_____

_____

_____

_____

_____

Treatment goals _____

Treatment preferences _____

Strengths _____

Adult

Psychiatric/MH Questionnaire (Continued)

Patient name	MHN	DOB	Age	Gender

Place one check (✓) next to those items that are of concern to you. Place two checks (✓ ✓) next to those items which are causing you the greatest difficulty:

- ☐ ☐ Depressed mood
- ☐ ☐ Crying spells
- ☐ ☐ Lack of energy/interest/motivation
- ☐ ☐ Decreased enjoyment in life/activities
- ☐ ☐ Suicidal thoughts
- ☐ ☐ Self-esteem/Confidence
- ☐ ☐ Decision making
- ☐ ☐ Social withdrawal
- ☐ ☐ Loneliness
- ☐ ☐ Anxiety/Stress/Nervousness
- ☐ ☐ Panic attacks (chest pain, heart racing sweating, shortness of breath lasting10 minutes or more)
- ☐ ☐ Worrying
- ☐ ☐ Feeling overwhelmed
- ☐ ☐ Fears
- ☐ ☐ Avoiding certain situations
- ☐ ☐ Difficulty concentrating
- ☐ ☐ Increased irritability
- ☐ ☐ Exposure to traumatic events
- ☐ ☐ Recurrent thoughts about past events
- ☐ ☐ Nightmares
- ☐ ☐ Startle easily
- ☐ ☐ Troubling repetitive thoughts or behaviors
- ☐ ☐ Repetitive checking behavior (making sure door is locked or stove shut off)
- ☐ ☐ Excessive collecting of items
- ☐ ☐ Counting excessively
- ☐ ☐ Preoccupied with germs or cleaning excessively
- ☐ ☐ Obsessive thoughts on medical issues
- ☐ ☐ Seeing things others do not see
- ☐ ☐ Hearing voices
- ☐ ☐ Strange or peculiar thoughts/behaviors
- ☐ ☐ Anger management problems
- ☐ ☐ Dramatic mood swings
- ☐ ☐ Violent thoughts or actions
- ☐ ☐ Alcohol abuse
- ☐ ☐ Drug abuse
- ☐ ☐ Gambling problems
- ☐ ☐ Sexual behavior problems

Other general concerns _____

_____

- ☐ ☐ Relationship with spouse or significant other
- ☐ ☐ Family relationships
- ☐ ☐ Relationships with friends or coworkers
- ☐ ☐ Problems staying in a relationship
- ☐ ☐ Feeling disconnected
- ☐ ☐ Work/School difficulties
- ☐ ☐ Financial stressors
- ☐ ☐ Legal stressors
- ☐ ☐ Religious/Spiritual concerns
- ☐ ☐ Loss/Grief/Death
- ☐ ☐ Domestic abuse exposure
- ☐ ☐ Emotional/Physical/Sexual abuse/neglect
- ☐ ☐ Child abuse exposure
- ☐ ☐ History of foster home placement
- ☐ ☐ Problem with police
- ☐ ☐ Frequent speeding tickets
- ☐ ☐ Suspended from school
- ☐ ☐ Destruction of property
- ☐ ☐ Preoccupation with weight
- ☐ ☐ Use of laxatives, diuretics or weight loss pills to lose weight
- ☐ ☐ Binge eating
- ☐ ☐ Self-induced vomiting
- ☐ ☐ Restricting food intake
- ☐ ☐ Excessive exercise
- ☐ ☐ Dental problems
- ☐ ☐ Difficulty with memory
- ☐ ☐ Increased desire to sleep
- ☐ ☐ Insomnia or disrupted sleep
- ☐ ☐ Decreased sexual interest
- ☐ ☐ Headaches
- ☐ ☐ Dizziness
- ☐ ☐ Diarrhea/Digestive problems
- ☐ ☐ Muscle tension
- ☐ ☐ Weight gain of 10 lbs. or more in 3 months
- ☐ ☐ Weight loss of 10 lbs. or more in 3 months
- ☐ ☐ Chest pain
- ☐ ☐ Shortness of breath
- ☐ ☐ Hot flashes/sweating

Other physical concerns _____

_____

Psychiatric/MH Questionnaire (Continued)

Patient name	MHN	DOB	Age	Gender

Does your depression worsen in the winter time _____

How many hours of sleep do you get in an average night _____ hours

Do you snore: ☐ Yes ☐ No

Psychiatric and/or AODA history

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

Name(s) of current mental health providers _____

Past outpatient mental health and/or AODA treatment:

Date of Service	Name of Provider	Clinic/Location Name

Psychiatric and/or AODA hospitalizations:

Date of Hospitalization	Involuntary or Voluntary	Hospital/Location Name

Have you ever had electroconvulsive therapy (ECT): ☐ Yes ☐ No

If yes, when _____ Where _____

Self-injury

Have you ever injured yourself on purpose: ☐ Yes ☐ No

If yes, explain _____

How recently have you injured yourself _____

Suicide

Have you ever attempted suicide: ☐ Yes ☐ No

If yes, how many times have you attempted _____

What means did you use to try to commit suicide _____

How recently have you attempted _____

Do you have guns in your home: ☐ Yes ☐ No If yes, are they locked: ☐ Yes ☐ No

Patient name	MHN	DOB	Age	Gender

Addictive behavior

Gambling

Have you ever gambled: ☐ Yes ☐ No If yes, how often _____

Do you have difficulty controlling your gambling: ☐ Yes ☐ No

Tobacco/Nicotine

Have you ever used tobacco: ☐ Yes ☐ No Age of first time use _____

If yes, which kind: ☐ Cigarettes ☐ Pipe ☐ Cigars ☐ Chewing tobacco ☐ Vaping

Are you currently using tobacco: ☐ Yes ☐ No

Caffeine

Daily use: ☐ None ☐ 1 – 3 servings per day ☐ 4 – 6 servings per day ☐ 6 or more servings per day

Alcohol

Are you currently using alcohol: ☐ Yes ☐ No

If yes, how often do you have an alcoholic drink:

☐ Monthly or less ☐ 2 – 3 times per week ☐ 2 – 4 times per month ☐ 4 or more times per week

How many servings per use _____ Age of first use _____ Age of regular use _____

Any history of:

Blackouts: ☐ Yes ☐ No Delirium tremens: ☐ Yes ☐ No

Tremors: ☐ Yes ☐ No Withdrawal seizures: ☐ Yes ☐ No

Longest period of sobriety _____

Drug Used	Last Use	First Use	Frequency
LSD			
PCP			
Barbiturates			
Cocaine			
Cough syrup			
Ecstasy			
Heroin			
Inhalants			
Marijuana			
Methamphetamines			
Mushrooms			
Prescription controlled substances			
Opiates			

Other addictive behaviors, describe _____

Patient name	MHN	DOB	Age	Gender

Medications

Check (✓) any of the following that you have taken:

Antipsychotic:

- ☐ ChlorproMAZINE (Thorazine®)
- ☐ Fluphenazine HCl (Prolixin®)
- ☐ Haloperidol (Haldol®)
- ☐ Loxapine succinate (Loxitane®)
- ☐ Mesoridazine (Serentil®)
- ☐ Perphenazine (Trilafon®)
- ☐ Pimozide (Orap®)
- ☐ Thioridazine (Mellaril®)
- ☐ Thiothixene (Navane®)
- ☐ Trifluoperazine (Stelazine®)

Atypical antipsychotic:

- ☐ ARIPiprazole (Abilify®)
- ☐ Asenapine sublingual (Asaphris®)
- ☐ CloZAPine (Clozaril®)
- ☐ Iloperidone (Fanapt®)
- ☐ Lurasidone (Latuda®)
- ☐ OLANZapine (ZyPREXA®)
- ☐ Paliperidone (Invega®)
- ☐ QUEtiapine (SEROquel®)
- ☐ RisperiDONE (Risperdal®)
- ☐ ZiprasidoneHCl (Geodon®)

Benzodiazepine:

- ☐ ALPRAZolam (Xanax®)
- ☐ Chlordiaze HCl (Librium®)
- ☐ ClonazePAM (KlonoPIN®)
- ☐ DiazePAM (Valium®)
- ☐ LORazepam (Ativan®)
- ☐ Temazepam (Restoril®)

Central nervous system agent:

- ☐ CloNIDine HCl (Catapres®)
- ☐ Donepezil (Aricept®)
- ☐ Galatamine hydrobromide (Razadyne®)
- ☐ GuanFACINE (Intuniv®)
- ☐ GuanFACINE (Tenex®)
- ☐ Memantine (Namenda®)
- ☐ Prazosin (Minipress®)
- ☐ Rivastigmine (Exelon®)

Extrapyramidal symptoms side effect:

- ☐ Benztropine (Cogentin®)
- ☐ Trihexyphenidyl (Artane®)

Monoamine oxidase inhibitor antidepressant:

- ☐ Phenelzine (Nardil®)
- ☐ Tranylcypromine sulfate (Parnate®)

Mood stabilizer and anticonvulsant:

- ☐ CarBAMezepine (TEGretol®)
- ☐ Divalproex (Depakote®)
- ☐ LamoTRIgine (LaMICtal®)
- ☐ Lithium carbonate (Eskalith CR®)
- ☐ OXcarbazepine (Trileptal®)
- ☐ Topiramate (Topamax®)

Non-barbiturate hypnotic:

- ☐ Chloral hydrate (Somnote®)
- ☐ Eszopiclone (Lunesta®)
- ☐ Ramelteon (Rozerem®)
- ☐ Zaleplon (Sonata®)
- ☐ Zolpidem (Ambien®)

Non-benzodiazepine:

- ☐ BusPIRone (BuSpar®)
- ☐ Gabapentin (Neurontin®)
- ☐ HydrOXYzine pamoate (Vistaril®)
- ☐ TiaGABine (Gabitril®)

Non-SSRI antidepressant:

- ☐ BuPROPion HCl (Wellbutrin®)
- ☐ Desvenlafaxine succinate (Pristiq®)
- ☐ DULoxetine (Cymbalta®)
- ☐ Fluvoxamine (Luvox®)
- ☐ Mirtazapine (Remeron®)
- ☐ TraZODone (Desyrel/Oleptro®)
- ☐ Venlafaxine (Effexor XR®)
- ☐ Vilazodone (Viibryd®)

Psychiatric/MH Questionnaire (Continued)

Patient name	MHN	DOB	Age	Gender

SSRI antidepressant:

- ☐ Citalopram (CeleXA®)
- ☐ Escitalopram (Lexapro®)
- ☐ FLUoxetine (PROzac®)
- ☐ Fluvoxamine (Luvox®)
- ☐ Fluvoxamine maleate (Luvox®)
- ☐ OLANZapine-FLUoxetine HCl (Symbyax®)
- ☐ PARoxetine HCl (Paxil®)
- ☐ Sertraline (Zoloft®)

Stimulants:

- ☐ Amphetamine/Dextroamphetamine (Adderall®)
- ☐ Armodafinil (Nuvigil®)
- ☐ Atomoxetine (Strattera®)
- ☐ Dexmethylphenidate (Focalin®)
- ☐ Dextroamphetamine (Dexedrine®)
- ☐ Lisdexamfetamine (Vyvanse®)
- ☐ Methylphenidate HCl (Ritalin®/Concerta®)
- ☐ Modafinil (Provigil®)

Substance dependency:

- ☐ Acamprosate (Campral®)
- ☐ Disulfiram (Antabuse®)
- ☐ Naltrexone (Revia®)

Triclyclic antidepressant:

- ☐ Amitriptyline (Elavil®)
- ☐ Amoxapine (Asendin®)
- ☐ Clomipramine (Anafranil®)
- ☐ Desipramine (Norpramin®)
- ☐ Doxepin (Sinequan®)
- ☐ Imipramine (Tofranil®)
- ☐ Maprotiline (Ludiomil®)
- ☐ Nortriptyline (Pamelor®)
- ☐ Protriptyline (Vivactil®)

Personal medical history

Allergies/Reactions _____

Current active medical problems _____

_____

Past medical history _____

_____

Past medical hospitalizations _____

_____

Past surgical procedures _____

_____

Do you have physical pain concerns: ☐ Yes ☐ No

Do you have a history of accidents, head injuries, seizures and blackouts: ☐ Yes ☐ No

If yes, what happened _____ Date _____

Do you have a history of sexually transmitted disease (gonorrhea, chlamydia, syphilis, hepatitis B or C, HIV): ☐ Yes ☐ No

Sexual preference: ☐ Heterosexual ☐ Homosexual ☐ Other _____

Psychiatric/MH Questionnaire (Continued)

Patient name	MHN	DOB	Age	Gender

Identify concerns with any of the following:

Fatigue, fever, or night sweats ..... ☐ Yes ☐ No

Recent weight loss/weight gain ..... ☐ Yes ☐ No
If yes, how many pounds _____

Skin problems (rash, jaundice) ..... ☐ Yes ☐ No
If yes, explain _____

Eyes (blurred vision, double vision) ..... ☐ Yes ☐ No
If yes, explain _____

Ears, nose, and/or throat (dizziness, recurrent sinus infections, hearing loss, vertigo, sore throat) ..... ☐ Yes ☐ No
If yes, explain _____

Respiratory problems (cough, shortness of breath, asthma) ..... ☐ Yes ☐ No
If yes, explain _____

Cardiovascular (palpitations, chest pain and history of hypertension) ..... ☐ Yes ☐ No
If yes, explain _____

Problems with breasts (pain, nipple discharge, lumps) ..... ☐ Yes ☐ No
If yes, explain _____

Gastrointestinal problems (difficulty swallowing, nausea, vomiting, upset stomach, indigestion, use of laxatives, blood in stool) ..... ☐ Yes ☐ No
If yes, explain _____

Genitourinary (pain or burning with urination; blood in urine) ..... ☐ Yes ☐ No
If yes, explain _____

Musculoskeletal (arthritis) ..... ☐ Yes ☐ No
If yes, explain _____

Endocrine (thyroid problems, diabetes) ..... ☐ Yes ☐ No
If yes, explain _____

Neurological (headaches, loss of consciousness, head injury, stroke, seizures) ..... ☐ Yes ☐ No
If yes, explain _____

Blood disorders (bruising easily, history of anemia) ..... ☐ Yes ☐ No
If yes, explain _____

OB/GYN (females only)

Number of pregnancies _____ Number of miscarriages _____

Number of living children _____ Last menstrual period _____

Method of birth control (abstinence, condoms, Essure®, Nexplanon®, diaphragm, Depo-Provera®, estrogen patch, hysterectomy, IUD, natural family planning, none, planning to conceive, oral birth control, partner vasectomy, same sex relationship, tubal ligation or post-menopausal) _____

Patient name	MHN	DOB	Age	Gender

7 – 10 days before your period, do you experience any of the following:

☐ Bloating ☐ Breast tenderness ☐ Food craving ☐ Increased appetite ☐ Irritability
☐ Cramps ☐ Sleeping problems ☐ Weight gain ☐ Increased depression

Mood changes with cycle or with birth control: ☐ Yes ☐ No

If yes, was birth control being used at the time: ☐ Yes ☐ No

Family history of medical and psychiatric illnesses

Diagnosis	Yes/No	Who	Which Medications Used
Dementia	☐ Yes ☐ No		
Developmental disabilities	☐ Yes ☐ No		
Diabetes	☐ Yes ☐ No		
Heart disease/hypertension	☐ Yes ☐ No		
High cholesterol	☐ Yes ☐ No		
Obesity	☐ Yes ☐ No		
Stroke	☐ Yes ☐ No		
Thyroid problems	☐ Yes ☐ No		
Cancer	☐ Yes ☐ No		
Tourette syndrome or tics	☐ Yes ☐ No		
Anxiety	☐ Yes ☐ No		
Attention deficit hyperactivity disorder (ADHD)	☐ Yes ☐ No		
Bipolar/Mania	☐ Yes ☐ No		
Complete suicide	☐ Yes ☐ No		
Attempted suicide	☐ Yes ☐ No		
Depression	☐ Yes ☐ No		
Electroconvulsive therapy	☐ Yes ☐ No		
Eating disorder	☐ Yes ☐ No		
Obsessive compulsive disorder	☐ Yes ☐ No		
Panic disorder	☐ Yes ☐ No		
Paranoia	☐ Yes ☐ No		
Schizophrenia	☐ Yes ☐ No		
Violence	☐ Yes ☐ No		
Alcohol abuse/dependence	☐ Yes ☐ No		
Drug abuse/dependence	☐ Yes ☐ No		

Patient name	MHN	DOB	Age	Gender

Social history

Where did you grow up _____

What is your birth order (example: oldest of 3) _____

Father's occupation _____ Mother's occupation _____

Check (✓) any of the following that you have had in your life:

- ☐ Grew up in a happy home
- ☐ Emotionally abused as a child or teenager
- ☐ Sexually abused as a child or teenager
- ☐ Childhood loss of a parent through abandonment
- ☐ Neglect or exposure to violence
- ☐ Grew up in a chaotic, unstable environment
- ☐ Physically abused as a child or teenager
- ☐ Verbally abused as a child or teenager
- ☐ Childhood loss of a parent through death
- ☐ Wartime combat

Quality of your relationship(s) with your parent(s) _____

Current type of residence (home, apartment, staying with others): _____

Who lives with you now in your household _____

Any previous primary relationships or marriages: ☐ Yes ☐ No

Length of the marriages _____

How many biological children do you have _____ Sons _____ Daughters _____

Who are your main sources of support _____

Do you have a valid driver's license: ☐ Yes ☐ No If no, why _____

Current financial status (stable, stressed, other) _____

Sources of income (employment, W2, SSI, spouse's income) _____

Educational history and learning needs

Did you graduate from high school: ☐ Yes ☐ No If yes, what year _____ School _____

Check (✓) any of the following that you had while in school:

- ☐ Behavioral problems
- ☐ Lack of interest
- ☐ Skipping school
- ☐ Special classes
- ☐ School suspension
- ☐ Learning difficulties
- ☐ Failing grades
- ☐ Refusal to go to school
- ☐ ADHD problems

Education after school _____

Grade performance in school _____ Preferred areas of study _____

Liked or disliked about school _____

Future educational goals _____

Emotional barriers to learning _____

Desire or motivation for learning _____

Psychiatric/MH Questionnaire (Continued)

Patient name	MHN	DOB	Age	Gender

Physical limitations for learning _____

Cognitive limitations for learning _____

Barriers to communication _____

Past intelligence and or neuropsychological testing: ☐ Yes ☐ No If yes, where _____

Employment or vocational history

Past employment history _____

Employment interests and skills _____

Where do you work _____

Current job title _____ How long have you been there _____

How many jobs have you had in your lifetime _____ How long was the longest job held _____

Job title while there _____

Have you ever been fired: ☐ Yes ☐ No If yes, why _____

Do you have any concerns or problems relating to your job _____

Have you ever served in the armed forces: ☐ Yes ☐ No If yes, how long _____

Branch of service _____ Discharge date _____

Wartime combat _____ Honorable discharge _____

Legal or arrest history

Check (✓) any of the following legal or arrest history that pertains to you:

☐ Assaulted another person	☐ Set fires	☐ Beaten animals	☐ DUI/DWI
☐ Past probation/parole	☐ Vandalism	☐ Alcohol/Drug use	☐ Bad checks
☐ Disorderly conduct	☐ Run away	☐ Charges pending	☐ Trespassing
☐ Failure to pay child support	☐ Theft	☐ Used weapon	

Are you currently on probation or parole: ☐ Yes ☐ No

If yes, name of officer you are working with _____

Other

Hobbies and/or leisure activities _____

Personal strengths _____

Cultural preferences _____

Religious preference _____

Signature/Title _____ Date (m/d/y) _____ /_____ /_____ Time _____

