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 ____________________________________________
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:

<table>
<thead>
<tr>
<th>Depressed mood</th>
<th>Relationship with spouse or significant other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crying spells</td>
<td>Family relationships</td>
</tr>
<tr>
<td>Lack of energy/interest/motivation</td>
<td>Relationships with friends or coworkers</td>
</tr>
<tr>
<td>Decreased enjoyment in life/activities</td>
<td>Problems staying in a relationship</td>
</tr>
<tr>
<td>Suicidal thoughts</td>
<td>Feeling disconnected</td>
</tr>
<tr>
<td>Self-esteem/Confidence</td>
<td>Work/School difficulties</td>
</tr>
<tr>
<td>Decision making</td>
<td>Financial stressors</td>
</tr>
<tr>
<td>Social withdrawal</td>
<td>Legal stressors</td>
</tr>
<tr>
<td>Loneliness</td>
<td>Religious/Spiritual concerns</td>
</tr>
<tr>
<td>Anxiety/Stress/Nervousness</td>
<td>Loss/Grief/Death</td>
</tr>
<tr>
<td>Panic attacks (chest pain, heart racing sweating, shortness of breath lasting 10 minutes or more)</td>
<td>Domestic abuse exposure</td>
</tr>
<tr>
<td>Worrying</td>
<td>Emotional/Physical/Sexual abuse/neglect</td>
</tr>
<tr>
<td>Feeling overwhelmed</td>
<td>Child abuse exposure</td>
</tr>
<tr>
<td>Fears</td>
<td>History of foster home placement</td>
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<tr>
<td>Avoiding certain situations</td>
<td>Problem with police</td>
</tr>
<tr>
<td>Difficulty concentrating</td>
<td>Frequent speeding tickets</td>
</tr>
<tr>
<td>Increased irritability</td>
<td>Suspended from school</td>
</tr>
<tr>
<td>Exposure to traumatic events</td>
<td>Destruction of property</td>
</tr>
<tr>
<td>Recurrent thoughts about past events</td>
<td>Preoccupation with weight</td>
</tr>
<tr>
<td>Nightmares</td>
<td>Use of laxatives, diuretics or weight loss pills to lose weight</td>
</tr>
<tr>
<td>Startle easily</td>
<td>Binge eating</td>
</tr>
<tr>
<td>Troubling repetitive thoughts or behaviors</td>
<td>Self-induced vomiting</td>
</tr>
<tr>
<td>Repetitive checking behavior (making sure door is locked or stove shut off)</td>
<td>Restricting food intake</td>
</tr>
<tr>
<td>Excessive collecting of items</td>
<td>Excessive exercise</td>
</tr>
<tr>
<td>Counting excessively</td>
<td>Dental problems</td>
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<tr>
<td>Preoccupied with germs or cleaning excessively</td>
<td>Difficulty with memory</td>
</tr>
<tr>
<td>Obsessive thoughts on medical issues</td>
<td>Increased desire to sleep</td>
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<tr>
<td>Seeing things others do not see</td>
<td>Insomnia or disrupted sleep</td>
</tr>
<tr>
<td>Hearing voices</td>
<td>Decreased sexual interest</td>
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<tr>
<td>Strange or peculiar thoughts/behaviors</td>
<td>Headaches</td>
</tr>
<tr>
<td>Anger management problems</td>
<td>Dizziness</td>
</tr>
<tr>
<td>Dramatic mood swings</td>
<td>Diarrhea/Digestive problems</td>
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<tr>
<td>Violent thoughts or actions</td>
<td>Muscle tension</td>
</tr>
<tr>
<td>Alcohol abuse</td>
<td>Weight gain of 10 lbs. or more in 3 months</td>
</tr>
<tr>
<td>Drug abuse</td>
<td>Weight loss of 10 lbs. or more in 3 months</td>
</tr>
<tr>
<td>Gambling problems</td>
<td>Chest pain</td>
</tr>
<tr>
<td>Sexual behavior problems</td>
<td>Shortness of breath</td>
</tr>
<tr>
<td>Other general concerns</td>
<td>Hot flashes/sweating</td>
</tr>
<tr>
<td>Other physical concerns</td>
<td></td>
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</tbody>
</table>
**Psychiatric/MH Questionnaire (Continued)**

<table>
<thead>
<tr>
<th>Patient name</th>
<th>MHN</th>
<th>DOB</th>
<th>Age</th>
<th>Gender</th>
</tr>
</thead>
</table>

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:

<table>
<thead>
<tr>
<th>Date of Service</th>
<th>Name of Provider</th>
<th>Clinic/Location Name</th>
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</tbody>
</table>

Psychiatric and/or AODA hospitalizations:

<table>
<thead>
<tr>
<th>Date of Hospitalization</th>
<th>Involuntary or Voluntary</th>
<th>Hospital/Location Name</th>
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</table>

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
**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 _________________

<table>
<thead>
<tr>
<th>Drug Used</th>
<th>Last Use</th>
<th>First Use</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>LSD</td>
<td></td>
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<tr>
<td>PCP</td>
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<td></td>
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<tr>
<td>Barbiturates</td>
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<td></td>
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<tr>
<td>Cocaine</td>
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<td></td>
<td></td>
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<tr>
<td>Cough syrup</td>
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<td></td>
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<tr>
<td>Ecstasy</td>
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<td></td>
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<tr>
<td>Heroin</td>
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<tr>
<td>Inhalants</td>
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<tr>
<td>Marijuana</td>
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<td></td>
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<tr>
<td>Methamphetamines</td>
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<td></td>
<td></td>
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<tr>
<td>Mushrooms</td>
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<tr>
<td>Prescription controlled substances</td>
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<td></td>
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<tr>
<td>Opiates</td>
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</tbody>
</table>

Other addictive behaviors, describe ___________________________________________________________________________
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®)
- OLANZapine (ZypREXA®)
- Paliperidone (Invega®)
- Quetiapine (SEROquel®)
- RisperiDONE (Risperdal®)
- ZiprasidoneHCl (Geodon®)

**Benzodiazipine:**
- ALPRAZolam (Xanax®)
- ClonazePAM (KlonopIN®)
- DiazePAM (Valium®)

**Central nervous system agent:**
- CloNIDine HCl (Catapres®)
- Donepezil (Aricept®)
- Galatamine hydrobromide (Razadyne®)
- Memantine (Namenda®)
- Prazosin (Minipress®)
- Rivastigmine (Exelon®)

**Extrapyramidal symptoms side effect:**
- Benzotropine (Cogentin®)
- Trihexyphenidyl (Artane®)

**Monoamine oxidase inhibitor antidepressant:**
- Phenelzine (Nardil®)
- Tranylcypromine sulfate (Parnate®)

**Mood stabilizer and anticonvulsant:**
- CarBAMezepine (TEGretol®)
- Divalproex (Depakote®)
- Lithium carbonate (Eskalith CR®)
- OXcarbazepine (Trileptal®)
- Topiramate (Topamax®)

**Non-barbiturate hypnotic:**
- Chlordiaze HCl (Librium®)
- Eszopiclone (Lunesta®)
- Ramelteon (Rozerem®)
- Zaleplon (Sonata®)
- Zolpidem (Ambien®)

**Non-benzodiazipine:**
- BusPIRone (BuSpar®)
- Gabapentin (Neurontin®)
- HydrOXYzine pamoate (Vistaril®)
- TiaGABine (Gabitril®)

**Non-SSRI antidepressant:**
- BuPROPion HCl (Wellbutrin®)
- Desvenlafoxine succinate (Pristiq®)
- DUloxetine (Cymbalta®)
- Fluvoxamine (Luvox®)
- Mirtazapine (Remeron®)
- Venlafaxine (Effexor XR®)
- Vilazodone (Viibryd®)
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®)
- Atomoxetine (Strattera®)
- Dextroamphetamine (Dexedrine®)
- Lisdexamfetamine (Vyvanse®)
- Methylphenidate HCl (Ritalin®/Concerta®)
- Modafinil (Provigil®)

Substance dependency:
- Acamprosate (Campral®)
- Disulfiram (Antabuse®)
- Naltrexone (Revia®)

Tricyclic 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 __________________________
Adult

Psychiatric/MH Questionnaire (Continued)

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) ____________________________________________
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

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Yes/No</th>
<th>Who</th>
<th>Which Medications Used</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia</td>
<td></td>
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<tr>
<td>Developmental disabilities</td>
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<tr>
<td>Diabetes</td>
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<td></td>
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<tr>
<td>Heart disease/hypertension</td>
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<td></td>
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<tr>
<td>High cholesterol</td>
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<tr>
<td>Obesity</td>
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<td></td>
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<tr>
<td>Stroke</td>
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<td></td>
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<tr>
<td>Thyroid problems</td>
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<tr>
<td>Cancer</td>
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<td></td>
<td></td>
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<tr>
<td>Tourette syndrome or tics</td>
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<td></td>
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<tr>
<td>Anxiety</td>
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<tr>
<td>Attention deficit hyperactivity disorder (ADHD)</td>
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<tr>
<td>Bipolar/Mania</td>
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<tr>
<td>Complete suicide</td>
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<tr>
<td>Attempted suicide</td>
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<tr>
<td>Depression</td>
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<tr>
<td>Electroconvulsive therapy</td>
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<tr>
<td>Eating disorder</td>
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<tr>
<td>Obsessive compulsive disorder</td>
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<tr>
<td>Panic disorder</td>
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<tr>
<td>Paranoia</td>
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<tr>
<td>Schizophrenia</td>
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<tr>
<td>Violence</td>
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<tr>
<td>Alcohol abuse/dependence</td>
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<tr>
<td>Drug abuse/dependence</td>
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</tbody>
</table>
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          ☐ Grew up in a chaotic, unstable environment
☐ Emotionally abused as a child or teenager          ☐ Physically abused as a child or teenager
☐ Sexually abused as a child or teenager          ☐ Verbally abused as a child or teenager
☐ Childhood loss of a parent through abandonment          ☐ Childhood loss of a parent through death
☐ Neglect or exposure to violence          ☐ 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          ☐ Special classes          ☐ Failing grades
☐ Lack of interest          ☐ School suspension          ☐ Refusal to go to school
☐ Skipping school          ☐ Learning difficulties          ☐ 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 ____________________________________________
### 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
- □ 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

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**Signature/Title** ___________________________ **Date** (m/d/y) _______ / _____ / _____ **Time** ______

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