* Please complete this questionnaire and bring it for your first appointment. You will notice that it is a lengthy questionnaire. It covers many details about you that will help better understanding of your concerns.

Patient Name: _____ **Sex:** _____

Date of Birth: _____ **Ethnicity/Race:** _____

Current relationship status: _____

Occupation: _____ **Years of education/Degree:** _____

Employer: _____

Who currently lives at home?

Name	Age	Sex	Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

What are the two issues you are the most concerned? How long have they been of concern; and how have they progressed?

1. _____

_____

_____

_____

2. _____

_____

_____

_____

_____

Has there been any particular event happened that has prompted this referral?

_____

_____

_____

_____

Who has recommended this referral? _____

What are your goals and hopes to achieve from this referral? _____

_____

_____

_____

_____

Current symptoms. Check all that apply.

	Decreased appetite		Increased appetite
	Sleeping difficulty		Sleeping too much
	Impulsivity		Lack of Concentration
	Temper/anger outbursts		Low energy/fatigue
	Self injurious behavior		Suicidal thought/comment
	Stomach upset		Headache
	Paranoia		Hallucination
	Fear/anxiety		Nervous habits
	Relationship Difficulties		Other:
	Other:		Other:

Previous psychiatric, psychological or mental health evaluation/treatment, if any.

Provider Name	Dates	Service	Outcome	Reason for Stopping

Previous psychiatric hospitalization or residential treatment, if any.

Facility	Dates	Service	Outcome

Previous or present treatment with medications to address emotional, behavioral or mental health reasons, if any.

Now	Past	Medication Name	Reason	Dosage	Outcome

Previous or present substance abuse issue.

	How often?	How much?	Treatment? Legal issues?
Cigarette			
Alcohol			
Other illicit drug (Name:)			
Other illicit drug (Name:)			

List any allergies to medications: _____

Physical medical/surgical issues.

Now	Past	Diagnoses	Treatment	Medication	Outcome

Any history of head injury or seizures? _____

_____

Any history of traumatic events in your life that have affected your life significantly? _____

_____

_____

Does anyone of the extended family suffer from any of the following? If so, relation to you?

Condition	Relation to You
Depression	
Bipolar Disorder	
Anxiety or Panic Attacks	
Alcohol Abuse	
Drug Abuse	
Schizophrenia/Psychosis	
Mental Retardation	
Learning Disorder	
Attention Deficit Disorder	
Tics/Tourette's Disorder	
Autism	

* Thank you for taking the time to complete this questionnaire.
* If there are other things you think would be important, please write them out on a separate piece of paper.
* Please bring, if available, any previous psychiatric or psychological evaluation.