Medical History Questionnaire

Patient Name:_____ Today's Date:_____

Address:_____Home Phone_____

City:_____State:_____Zip:_____Cell Phone_____

Birth Date:_____ Age_____

School:_____Year of Schooling_____JOB: **Y/N** if yes, where_____Duties_____Hours per week_____

Reside with: Mom ___Dad___ Both___Other_____

MEDICAL HISTORY

Do you have any allergies to medications: No___ Yes___ If yes, explain:_____

List all major injuries, surgeries and/or hospitalizations you have had:_____

_____

Are you pregnant and/or nursing? No___ Yes___ If yes, how far along?_____

List all Mental Health hospitalizations (include partial hospital, day treatment, inpatient, addiction tx inpatient or outpatient)_____

_____

List all medical and/or mental health conditions for which you take medications, including over the counter medications, herbal and supplements, birth control pills and acne creams:

MEDICAL CONDITION	MEDICATIONS	DOSE	FREQUENCY	SIDE EFFECTS

List all mental health medications you have taken in the past. Please comment on positive and negative effects from them.

*******PLEASE CONTINUE TO PAGE TWO******

SOCIAL HISTORY

Who are the major support people you turn to when you are distressed? What is the relationship to you?_____

_____

Are there issues of Loss? No___ Yes___

Are there issues of Trauma? No___ Yes___

Do you drive? No___Yes___

Do you use tobacco products? No___Yes___Past___ If yes, type/amount/how long:_____

Do you drink alcohol? No___Yes___ Past___ If yes, type/amount/how long:_____

Do you use illegal drugs? No___Yes___ Past___ If yes, type/amount/how long:_____

Have you ever been arrested? No___ Yes___ If yes, for what?_____

Are you sexually active? No___Yes___Past___ If yes, any pregnancies/STD's:_____

Do you exercise regularly? No___ Yes___ Past___ Favorite activities_____

What are your interests/hobbies?_____

PSYCHIATRIC REVIEW OF SYMPTOMS

Anxiety	No___ Yes___ ?___	Overly Sensitive	No___ Yes___ ?___
Panic Attacks	No___Yes___ ?___	Defensive	No___ Yes___ ?___
Nightmares	No___ Yes___ ?___	Irritable	No___ Yes___?___
Insomnia	No___ Yes___ ?___	Bad Temper	No___ Yes___?___
Sleep too much	No___ Yes___ ?___	Angry	No___ Yes___?___
Flashbacks	No___ Yes___?___	Rageful	No___ Yes___?___
Sad	No___Yes___ ?___	Suspcious	No___ Yes___ ?___
Frequent crying	No___ Yes___ ?___	Self Harming/Cutting	No___Yes___ ?___
Hopeless	No___ Yes___ ?___	Wish you were dead	No___ Yes___ ?___
No Energy	No___ Yes___ ?___	Suicidal thoughts	No___ Yes___ ?___
Poor Concentration	No___ Yes___ ?___	Suicidal fantasies	No___ Yes___ ?___
Loss of Interest	No___ Yes___ ?___	Suicide Attempts	No___ Yes___ ?___
Poor Motivation	No___ Yes___ ?___	Racing thoughts	No___ Yes___ ?___
Poor Focus	No___ Yes___ ?___	Hearing voices	No___ Yes___ ?___
Intrusive Thoughts	No___ Yes___ ?___	Repetitive Behaviors	No___ Yes___ ?___
Counting/Checking habits	No___ Yes___ ?___	Cleaning habits	No___ Yes___ ?___

*******PLEASE CONTINUE ON PAGE THREE*******

FAMILY HISTORY

	Living	Deceased
Immediate family members: Mother	_____	_____
Father	_____	_____
Number of sisters	_____	_____
Number of brothers	_____	_____
Number of children	_____	_____

Please note any family history (parents, grandparents, siblings, children, aunts, uncles, cousins; living or deceased) for the following:

DISEASE/CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Anxiety/Panic Disorder	___	___	___	_____
Depression	___	___	___	_____
Bipolar(Manic/Depression)	___	___	___	_____
Schizophernia	___	___	___	_____
Addiction	___	___	___	_____
Trauma	___	___	___	_____
Suicide Attemps	___	___	___	_____
Suicide Deaths	___	___	___	_____
Cancer	___	___	___	_____
Diabetes	___	___	___	_____
Heart Disease	___	___	___	_____
High Blood Pressure	___	___	___	_____
Kidney Disease	___	___	___	_____
Auto Immune Disease	___	___	___	_____
Fibromyalgia	___	___	___	_____
Thyroid Disease	___	___	___	_____
OCD	___	___	___	_____

Other_____

Thank you. Please know the information you have disclosed will be held in strict confidence with the exception of a life threatening situation.