**PATIENT HISTORY QUESTIONNAIRE**

**PATIENT INFORMATION**

Patient Name: Sex: Male\_\_\_ Female\_\_\_

Date of Birth: Age: Social Security Number:

Address:

Home Phone: Cell Phone:

Work Phone: Fax:

Marital Status: Single\_\_\_ Married\_\_\_ Divorced\_\_\_ Separated\_\_\_ Partner\_\_\_

Referred by:

**EMPLOYER INFORMATION**

Company Name: Title:

Business Phone: Business Address:

May I leave a detailed message for you here? Yes\_\_\_ No\_\_\_

**EMERGENCY CONTACT**

Name: Home Phone:

Business Phone: Cell Phone:

Relationship to Patient:

**CURRENT MENTAL HEALTH CARE (e.g., psychiatrist, psychologist, LCSW, counselor, other)**

Name and Title:

Phone: Address:

Name and Title:

Phone: Address:

**YOUR GENERAL MEDICAL DOCTOR**

Name:

Phone: Address:

**YOUR OTHER MEDICAL SPECIALISTS**

Name: Speciality:

Phone: Address:

Length of Time Seen:

Name: Speciality:

Phone: Address:

Length of Time Seen:

**YOUR PREFERRED PHARMACY**

Pharmacy Name:

Town, State:

Telephone: Fax:

**REASON(S) FOR SEEKING TREATMENT**

Please state the reasons why you are seeking treatment. When and how did the problem(s) begin? What has been done so far to try to alleviate the problem(s)? Please describe any physical symptoms you are experiencing.

**DEPRESSION QUESTIONNAIRE (PHQ-9)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Over the last **2 weeks**, how often have you been bothered by any of the following problems? Answer each question by marking the appropriate frequency and then add up the corresponding numbers. | Not at all(0) | Several days (1) | More than half the days (2) | Nearly every day (3) |
| Little interest or pleasure in doing things? |  |  |  |  |
| Feeling down, depressed or hopeless? |  |  |  |  |
| Trouble falling or staying asleep, or sleeping too much? |  |  |  |  |
| Feeling tired or having little energy? |  |  |  |  |
| Poor appetite or overeating? |  |  |  |  |
| Feeling bad about yourself – or that you are a failure or have let yourself or your family down? |  |  |  |  |
| Trouble concentrating on things, such as reading the newspaper or watching television? |  |  |  |  |
| Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual? |  |  |  |  |
| Thoughts that you would be better off dead or of hurting yourself in some way? |  |  |  |  |

***DEPRESSION SEVERITY: TOTAL \_\_\_/27***

***None 0-4***

***Mild 5-9***

***Moderate 10-14***

***Moderately Severe 15-19***

***Severe 20-27***

***If you have been bothered by any of the problems listed above, please answer the following***:

How difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not at all difficult\_\_\_ Somewhat difficult\_\_\_ Very difficult\_\_\_ Extremely difficult\_\_\_

**MOOD DISORDER QUESTIONNAIRE (MDQ)**

|  |
| --- |
| 1. Has there ever been a period of time when you were not your usual self and…

 YES NO  |
| …You felt so good or so hyper that other people thought you were not your normal self, or you were so hyper that you got into trouble? |  |  |
| …You were so irritable that you shouted at people or started fights or arguments? |  |  |
| …You felt much more self-confident than usual? |  |  |
| …You got much less sleep than usual and found you didn’t really miss it? |  |  |
| …You were much more talkative or spoke faster than usual? |  |  |
| …Thoughts raced through your head or you couldn’t slow your mind down? |  |  |
| …You were so easily distracted by things around you that you had trouble concentrating or staying on track? |  |  |
| …You had much more energy than usual? |  |  |
| …You were much more active or did many more things than usual? |  |  |
| …You were much more social or outgoing than usual; for example, you telephoned friends in the middle of the night? |  |  |
| …You were much more interested in sex than usual? |  |  |
| …You did things that were unusual for you or that other people might have thought were excessive, foolish, or risky? |  |  |
| …Spending money got you or your family into trouble? |  |  |
| 1. If you checked YES to more than one of the above, have several of these ever happened during the ***same period of time***?
 |  |  |
| 1. How much of a problem did any of these cause you--like being unable to work; having family, money, or legal troubles; getting into arguments or fights?

 No problem\_\_\_ Minor problem\_\_\_ Moderate problem\_\_\_ Serious problem\_\_\_ |
| 1. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts,uncles) had manic-depressive illness or bipolar disorder?
 |  |  |
| 1. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?
 |  |  |

**MENTAL HEALTH HISTORY**

**Inpatient Psychiatric Hospitalizations:**

Dates Length of Admission Major Symptoms Treatment

**Psychiatric or Other Mental Health Treatment History (e.g., past therapists, counselors, psychiatrists, intensive outpatient programs, etc.):**

Dates Provider Name and degree City, State Symptoms Treatment

**Harm to Self or Others**

Harm to self? YES\_\_\_ NO\_\_\_

If yes, type and number of times (e.g. cutting, suicide attempt):

Hospitalized? YES\_\_\_ NO\_\_\_

Harm to others? YES\_\_\_ NO\_\_\_

If yes, type and number of times:

Victim(s) hospitalized: YES\_\_\_ NO\_\_\_

**CURRENT MEDICATIONS**

**List ALL of the medications you are currently taking either regularly or as needed, by prescription or over-the-counter. Include any hormones, vitamins, or herbal or other supplements.**

DRUG NAME DOSE HOW OFTEN REASON TAKING EFFECT DATE STARTED

**PREVIOUS MEDICATIONS**

**List any medications you have taken previously (especially antidepressants, anxiolytics, antipsychotics, etc.)**

DRUG NAME DOSE HOW OFTEN REASON TAKEN DATES EFFECT REASON STOPPED

**MEDICAL HISTORY**

Month and year of your last complete physical exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any significant medical illnesses? YES\_\_\_ NO\_\_\_

*If yes, please give description and approximate dates.*

Have you ever been told you have a thyroid problem? YES\_\_\_ NO\_\_\_

Have you ever been treated with thyroid medication? YES\_\_\_ NO\_\_\_

Have you had any blood pressure trouble (too high or too low)? YES\_\_\_ NO\_\_\_

Are you troubled by headaches? YES\_\_\_ NO\_\_\_

Have you ever suffered head injuries, concussions, or seizures? YES\_\_\_ NO\_\_\_

*If yes, describe type and sequelae*:

Do you have, or have you had (check all that apply and describe)

\_\_\_Dizzy spells:

\_\_\_Weakness in arms or legs:

\_\_\_Double vision:

\_\_\_Blurry vision:

\_\_\_Seizures:

\_\_\_Other neurological problems:

Have you had any notable accidents or injuries? YES\_\_\_ NO\_\_\_

*If so, please give description, dates, and treatment rendered.*

Have you ever been hospitalized for medical reasons? YES\_\_\_ NO\_\_\_

*If so, please give description, dates, and treatment rendered.*

What is your sleep pattern like normally?

How does this change when you’re depressed/anxious/manic/other? Do you take naps?

Have you had any significant weight changes recently? YES\_\_\_ NO\_\_\_

*If so, how much gained or lost in what period of time?*

Current weight: \_\_\_\_\_\_\_ Height:\_\_\_\_\_\_\_\_\_

**SURGICAL HISTORY**

Have you had any surgeries? YES\_\_\_ NO\_\_\_

*If so, please give dates and types of surgery.*

***Females only:***

Are you having menstrual periods? YES\_\_ NO\_\_ Regular? YES\_\_ NO\_\_ Date of Last menstrual period: \_\_\_\_\_\_

Are you currently pregnant, breastfeeding, or anticipating becoming pregnant? YES\_\_\_ NO\_\_\_

Are there any physical/emotional changes prior to, or related to, your period? YES\_\_\_ NO\_\_\_

**ALLERGIES**

Do you have any allergies to medications? YES\_\_\_ NO\_\_\_

*List name of medication and TYPE OF ADVERSE REACTION:*

Do you have any food/environmental allergies? YES\_\_\_ NO\_\_\_

*List name of allergen and TYPE OF ADVERSE REACTION:*

**FAMILY PSYCHIATRIC HISTORY**

Please describe any emotional or psychiatric problems in blood relatives (such as depression, bipolar disorder, schizophrenia, obsessive-compulsive disorder, panic attacks, attention deficit hyperactivity disorder, alcoholism, drug abuse, suicide, violence, emotional instability, abnormal or eccentric personalities) and any treatment they have received. Include any learning disabilities. (If you don’t know a diagnosis or treatment, just put “don’t know.”)

Father:

Mother:

Brothers, Sisters:

Children:

Extended Family (such as aunts, uncles, cousins, grandparents, great-grandparents, grandchildren, etc.):

**FAMILY MEDICAL HISTORY**

Is there any history of serious medical problems in your family members (blood relatives)? YES\_\_\_ NO\_\_\_

*If yes, please list which members and their condition (cancer, thyroid, high blood pressure, heart problems, etc):*

Is there any family history (blood relatives) of thyroid problems? YES\_\_\_ NO\_\_\_

*If yes, please list which members and the type of thyroid problem:*

**SOCIAL HISTORY**

**Relationships**

Describe your current living situation (Do you live alone? With others? What is their relationship to you?).

What is your sexual orientation? Heterosexual\_\_\_ Homosexual\_\_\_

History of prostitution/patron? YES\_\_\_ NO\_\_\_

If heterosexual, what is your marital status? Married\_\_\_ Unmarried\_\_\_

Previously married? YES\_\_\_ NO\_\_\_

Number of times/duration:

*Please explain nature of conflicts:*

If homosexual, what is your partnership/marriage status? Partnered/Married\_\_\_ Unpartnered/Unmarried\_\_\_

Have you had previous long-term relationships with a partner/spouse YES\_\_\_ NO\_\_\_

Number of times/duration:

*Please explain nature of conflicts:*

Are you currently sexually active? YES\_\_\_ NO\_\_\_

*If yes, do you practice safe sex?* YES\_\_\_ NO\_\_\_

Are you satisfied with your sex life? YES\_\_\_ NO\_\_\_

*If no, please describe:*

Are you currently experiencing physical, emotional, or sexual abuse? YES\_\_\_ NO\_\_\_

*If so, what type and by whom (all information provided is strictly confidential)*

Have you ever been physically, emotionally, or sexually abused? YES\_\_\_ NO\_\_\_

*If so, when, what type, and by whom? (all information provided is strictly confidential)*

**Spirituality and Fun**

Religious or spiritual affiliation, if any: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is spirituality an important dimension in your life?: YES\_\_\_ NO\_\_\_

Recreation (some typical activities you do for fun):

**Military Service** YES\_\_\_ NO\_\_\_

Branch:

Highest rank:

Dates of service:

 Type of discharge:

**Where were you born and raised?**

**Education:**

Name and location of High school/ graduation date:

Name and location of College/graduation date:

* Type of degree and major(s) :

Name and location of Graduate School/graduation date:

* Type of degree and field of study:

Name and location of Professional school/graduation date:

* Type of degree and field of study:

**Substance Use/Misuse**

Do you drink alcohol? YES\_\_\_ NO\_\_\_

* Have you ever felt you should cut down on your drinking? YES\_\_\_ NO\_\_\_
* Have people annoyed you by criticizing your drinking? YES\_\_\_ NO\_\_\_
* Have you ever felt bad or guilty about your drinking? YES\_\_\_ NO\_\_\_
* Have you ever had a drink first thing in the morning to

steady your nerves or get rid of a hangover (eye-opener)? YES\_\_\_ NO\_\_\_

Do you use tobacco products? YES\_\_\_ NO\_\_\_

*If yes, what type and how much?*

Do you drink coffee, tea, or other caffeinated drinks? YES\_\_\_ NO\_\_\_

I*f yes, what type and how much?*

Have you ever used other drugs (such as marijuana, cocaine, LSD, heroin, etc.)? YES\_\_\_ NO\_\_\_

*If yes, which, how much, and when?*

Have you ever used drugs intravenously? YES\_\_\_ NO\_\_\_

*If yes, which, how much, and how recently?*

Have you ever been in a drug or alcohol detox and rehabilitation program? YES\_\_\_ NO\_\_\_

*If yes, name/location of program and date(s) of treatment:*

**Legal History**

Do you have current or past legal problems? YES\_\_\_ NO\_\_\_

*If yes, please describe:*

Have you ever spent time in jail? YES\_\_\_ NO\_\_\_

*If yes, please describe:*

**DEVELOPMENTAL HISTORY**

Did your mother experience any complications/illnesses during her pregnancy with you? YES\_\_\_ NO\_\_\_

*If yes, describe:*

Were you born full term? YES\_\_\_ NO\_\_\_

*If born premature, how many weeks?*

Did you reach your developmental milestones on time (walking, talking, etc.)? YES\_\_\_ NO\_\_\_

*If no, describe:*

Did you have any serious childhood illnesses? YES\_\_\_ NO\_\_\_

*If yes, describe type and sequelae:*

How were your grades in grammar school? \_\_\_\_\_ High school? \_\_\_\_\_

Were you diagnosed with any learning disabilities? YES\_\_\_ NO\_\_\_

*If yes, describe type and intervention:*

Describe your personality growing up—were you easy-going, shy, rowdy, outgoing, popular, athletic, studious, etc.?

Describe your household and family environment growing up:

List your **parents** (Biological, adoptive, step, etc.):

Name Birth date Education Occupation Health Status Where resides Frequency of Contact

List all of your **brothers and sisters** in order of birth.

Name Birth date Education Occupation Health Status Where resides Frequency of Contact

List your **children** (if applicable) in order of birth:

Name Birth date Occupation Health Status Where resides Frequency of Contact

**What is your profession or trade?**

**Employment History**

Employer Job Title Date Started Date Ended Reason for Leaving

Is there anything else you feel I should know about you or that you would like to mention at this time?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

**Thank you for taking the time to complete this questionnaire.**

**I look forward to meeting you!**

***-Dr. Kinkead-Acree***