Psychiatric & Psychological Associates of Durham, PLLC

PATIENT QUESTIONNAIRE

Patient Name: _____ **Date:** _____

This completed form will help the clinician understand your needs. Please fill it out to the best of your knowledge.

1. The person completing this form is: ☐ Self ☐ Family Member ☐ Caregiver ☐ Other:_____
2. Social Life
   A. Marital Status ☐ Never Married ☐ Married - How long?_____ ☐ Divorced - How long? _____
   ☐ Previous marriages? 1 2 3 4 5+ times ☐ Widowed - How long? _____
   ☐ Separated - How long?_____ ☐ Committed relationship / partner - How long? _____

   B. Names of Persons in Household | Age | Relationship to Patient | Quality of Relationship

   _____ _____ _____ _____
   _____ _____ _____ _____
   _____ _____ _____ _____
   _____ _____ _____ _____

   C. Names of other relatives / significant friends you turn to for help or to talk with: _____
   _____

   D. Is there violence in household or with significant other? ☐ Yes ☐ No

   E. Do you participate in: clubs, organizations, etc? ☐ Yes ☐ No religious / spiritual activities? ☐ Yes ☐ No
3. Education
   A. Highest grade / degree completed: _____ Grades: ☐ Above Average ☐ Average ☐ Below Average
   B. Learning disabilities _____
4. Military Service History: _____ Ending Rank: _____ Discharge Type: _____
5. Employment History:
   A. Current Employment: ☐ full-time ☐ part-time ☐ self employed ☐ unemployed / student ☐ other _____
   B. If employed, type of work: _____
   C. Means of financial support for household: _____
6. Medical History
   A. Current Health concerns (include allergies): _____
   _____
   B. Medication(s) currently used: ☐ NONE

   Medication | Dose | Doctor Prescribing | Why prescribed: | Dates:

   _____ _____ _____ _____ _____
   _____ _____ _____ _____ _____
   _____ _____ _____ _____ _____
   _____ _____ _____ _____ _____

   C. Treatment(s) _____
   _____
   D. Treating Physicians(s): _____
   Address: _____Phone:_____ Fax: _____

PLEASE CONTINUE ON BACK OF PAGE

E. Chronic pain: ☐ Yes ☐ No If yes, explain: _____

F. Handicapping conditions: _____

G. Date of last physical: _____

H. Past Hospitalizations (Medical, Psychiatric, Chemical Dependency) ☐ NONE

Date(s):	Reasons:	Hospital:
_____	_____	_____
_____	_____	_____
_____	_____	_____

I. Previous Psychiatry, Psychotherapy, EAP, or Chemical Dependency Services: ☐ NONE

Facility / Counselor Name:	Dates Seen:	Why Seen:	Helpful:
_____	_____	_____	☐ Yes ☐ No
_____	_____	_____	☐ Yes ☐ No
_____	_____	_____	☐ Yes ☐ No

J. Have you ever taken work leave for mental health / chemical dependency problems? ☐ Yes ☐ No

K. Family history of mental illness, substance abuse, and suicide: _____

7. Health Behaviors:

Tobacco use:	Type: _____	How often: _____
Alcohol use	Type: _____	How often: _____
Substance abuse	Type: _____	How often: _____
Caffeine:	Amount: _____	How often: _____
Exercise:	Type: _____	How often: _____

8. Ethnicity, nationality, race or cultural influences: _____

9. Gender Identity: _____

10. Legal History:

Have you ever been arrested?	☐ Yes	☐ No
Have you ever been convicted of a crime?	☐ Yes	☐ No
Are you presently on parole or probation?	☐ Yes	☐ No
Have you ever been involved in a lawsuit?	☐ Yes	☐ No

If yes, please explain:_____

11. Please check any difficulties that are presently troubling you:

☐ Financial / employment	☐ Low self-confidence	☐ Headaches
☐ Feeling nervous/worrying	☐ Unable to relax	☐ Spiritual Concerns
☐ Feeling sad or depressed	☐ Suicidal thoughts / harming myself	☐ Sleep loss
☐ Drug or alcohol problems	☐ Anger / temper problems	☐ Nightmares
☐ Fear of future	☐ Unusual fears	☐ Exhaustion
☐ Frequent crying	☐ Problems between parent & child	☐ Loss of interest
☐ Unplanned pregnancy	☐ Problems with spouse / partner	☐ School problems
☐ Separation / divorce	☐ Eating / weight problems	☐ Sexual concerns

12. Why are you seeking professional help at this time: _____

_____

_____ _____

Date Patient / Responsible Adult Signature