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

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. 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:____________________

10. 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

11. Why are you seeking professional help at this time: ____________________

____

________________ Date

________________ Patient / Responsible Adult Signature