SARATOGA
BEHAVIORAL HEALTH

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# QUESTIONNAIRE FOR NEW PATIENTS

Please complete this questionnaire and bring it with you when you come for your appointment. If you need additional space, please use the back of the page. All of the information on this questionnaire is confidential.

Date: _____

Name: _____ DOB: _____ SSN:_____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (Home) _____ (Cell) _____ (Work) _____

Emergency Contact: _____ Relationship: _____

Phone (Home) _____ (Cell) _____

Primary Care Physician: _____

Address: _____Phone: _____

Who referred you to us? _____

**Insurance Information**

Insurance Company: _____ Insurance Phone: _____

Subscriber: _____ ID: _____

Subscriber's Employer: _____ DOB: _____ SSN: _____

Patient's relationship to subscriber: _____

Secondary Insurance Company: _____ ID: _____

Pharmacy: _____ Phone: _____

Address: _____

**I. Please state the reason you are seeking consultation.**

What is the problem(s) that you are experiencing and would like help with?

When and how did the problem(s) begin?

Please indicate how much your problems have been interfering with your daily life. For example: work, social life, leisure, family life and ability to carry out home responsibilities.

Are there any other significant stresses currently affecting you and/or your family life (e.g., financial concerns, health problems, extended family concerns or conflicts, work related stress, etc.)? ◯ YES ◯ NO IF YES, please describe:

**II. Substance Use**

Do you smoke cigarettes? ◯ YES ◯ NO

IF YES, how many cigarettes daily? _____ For how many years? _____

Do you drink caffeinated beverages (coffee, tea, or so_ drinks)? ◯ YES ◯ NO

IF YES, how many caffeinated drinks per week? ____

Do you drink alcohol? ◯ YES ◯ NO

IF YES, how many drinks per week? _____

**III. Psychiatric Treatment History**

Have you ever been hospitalized for psychiatric treatment? ◯ YES ◯ NO

IF YES, please specify:

Name of Hospital: _____Date of hospitalization: from_____ to _____

Are you currently seeing a therapist or counselor? ◯ YES ◯ NO

IF YES, please specify:

Are you currently taking any medication for treatment of psychiatric or emotional problems? ◯ YES ◯ NO IF YES, please specify:

| Medication(s) | Dose and frequency | Length of Time | Benefits and/or side effects |
|---|---|---|---|

Have you been prescribed psychiatric medications in the past?◯ YES ◯ NO IF YES, please specify:

| Medication(s) | Dose and frequency | Date | Reason for Discontinuing |
|---|---|---|---|

**IV. Medical History**

Have you experienced an allergic or severe adverse reaction to medications(s)? Please specify the medication and the reaction: _____

_____

Overall, how would you describe your physical health?

◯ Excellent ◯ Very Good ◯ Good ◯ Fair ◯ Poor

Have you suffered from any of the following medical problems? (Check all that apply)

| | | |
|---|---|---|
| ◯ asthma | ◯ high blood pressure | ◯ stroke |
| ◯ AIDS or HIV | ◯ hepatis | ◯ headaches |
| ◯ cancer | ◯ hormonal problems | ◯ surgery |
| ◯ cataract | ◯ kidney problems | ◯ sexually transmitted disease |
| ◯ glaucoma | ◯ liver problems | ◯ hearing impairment |
| ◯ diabetes | ◯ prostate illness | ◯ heart disease |
| ◯ head injuries | ◯ seizures | ◯ thyroid condition |
| ◯ ulcers | ◯ nausea/vomiting | ◯ constipation or diarrhea |
| ◯ urinary problems | ◯ dizziness/vertigo | ◯ chest pain |

Have you been hospitalized for a medical illness in the last 5 years? ◯ YES ◯ NO

IF YES to any of above, please provide details: _____

_____

Current height: _____ Current weight: _____

Are you currently taking any medication other than the psychiatric medications listed above (include prescription medications, birth control pills, and over-the counter medicines, such as cold or allergy preparations)? ◯ YES ◯ NO IF YES, please specify below:

| Medication | Dose and frequency | Length of Time | Reasons for taking |
|---|---|---|---|

**V. Social History**

Marital status ◯ Married ◯ Separated

◯ Divorced ◯ Widowed

◯ Never Married

Do you have any children? ◯ YES ◯ NO IF YES, please specify the ages of your children:

_____

Educational History:

◯ 8th grade or less ◯ some high school ◯ high school graduate or equivalency (GED)

◯ some college ◯ college graduate ◯ advanced college degree

Your occupation: _____

How long have been in your current position? _____

**VI. Family History**

Have any of your biological relatives had mental health problems or been diagnosed with a mental illness? ◯ YES ◯ NO IF YES, please describe: