Patient name			
MHN	DOB	Age	Gender

Psychiatric/MH Questionnaire

Appointment date (month/day/year) _____ /_____ /_____ Therapist ____________________

Answer these questions as completely as possible prior to attending your first appointment. Your responses will help us learn about your circumstances and assist you with individualized treatment for your problems.

Street address ____________________ City or town ____________________

Telephone number: Work ____________________ Home ____________________

Do you have a preference where we contact you ____________________

Ethnicity: ☐ White ☐ African American ☐ Native American ☐ Hispanic ☐ Asian
☐ Middle Eastern ☐ Other ____________________

Relationship status: ☐ Married ☐ Domestic partner ☐ Single ☐ Divorced ☐ Separated
☐ Widowed ☐ Other ____________________

Employment status: ☐ Employed full-time ☐ Employed part-time ☐ Unemployed ☐ Disabled
☐ Retired ☐ Homemaker ☐ Other ____________________

Do you have any special/disability needs we need to be aware of ____________________

Who referred you to us ____________________

Is it OK to send information to referral source or primary physician: ☐ Yes ☐ No

Presenting problem/history of present problem

What problems do you need assistance with: ☐ Depression ☐ Anxiety ☐ Relationship problem
☐ Anger or irritability ☐ Adjustment to major life change ☐ Alcohol/Drug abuse
☐ Coping with an illness or disability ☐ Other (describe) ____________________

Briefly describe the history of your problem and what you have tried to do about it so far ____________________

____

____

____

____

____

____

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Psychiatric/MH Questionnaire (Continued)

Patient name	MHN	DOB	Age	Gender

Psychiatric and/or AODA history

Do you currently have a psychiatrist, psychologist, social worker or counselor: ☐ Yes ☐ No

If yes, name(s) ___

List and describe all past treatment for psychological/psychiatric concerns or alcohol/drug problems:

Year	Doctor/Therapist	Inpatient/ Outpatient	Type of Treatment Name & Location of Treatment Facility *(Include medication, psychotherapy, counseling, alcohol or drug counseling, psychological testing, ECT, etc.)*

Past medical history

Who is your personal physician ___ Last appointment ___

Describe surgeries, major illnesses, accidents or hospitalizations for medical problems: ☐ None

Year	Where Treated	Type of Illness/Operation	Doctor/Therapist

Describe any current medical problems ___

___

Current Medication and Dose	Prescription	Non-prescription	How Often	What For

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Patient name	MHN	DOB	Age	Gender

List any allergies/reactions (plants, animals, medications) ____

____

	Tobacco	Caffeine	Alcohol	Street Drugs
Date last used				
Amount per day				
Tried to quit	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Family psychiatric history

Describe any family history of psychological difficulties, psychiatric illness, alcohol or drug abuse, history of violence or suicidal behavior:

☐ Psychiatric ☐ Alcohol/Drug ☐ Suicidal ☐ Violent behavior

____

____

____

Social history

	Type of Work	Age or Date of Death	Physical Illness
Father			
Mother			
Brother/ Sister			
Spouse/ Partner			
Children/ Stepchildren			

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Psychiatric/MH Questionnaire (Continued)

Patient name	MHN	DOB	Age	Gender

Any previous primary relationships/marriages: ☐ Yes ☐ No If yes, explain ______________________________

____

What was your birth order and number of children in family (for example: oldest of 3, etc.) ______________________

____

Graduated from high school: ☐ Yes ☐ No If yes, what year ______________________________

Education after high school: ☐ Yes ☐ No If yes, describe ______________________________

Describe any school problems ____

____

Where are you employed ____

How long have you been there ______________ Job title ______________________________

Describe any job problems/concerns ____

____

____

Any legal or arrest history: ☐ Yes ☐ No Probation/Parole: ☐ Yes ☐ No

If yes, what type: ☐ Traffic offenses ☐ Alcohol/Drug ☐ Property/Financial ☐ Assault/Violence/Weapons

Any armed services history: ☐ Yes ☐ No If yes, how long __________ years

Discharge: ☐ Honorable ☐ Other Branch of service ______________________________

Active religious practice: ☐ Yes ☐ No If yes, what religion ______________________________

Who lives with you now in your household ____

____

Hobbies and leisure activities ____

____

Any other comments or concerns you want to share ____

____

____

____ ______________________ _____ /_____ /_____

Patient signature (Patient's legal representative) (Relationship) Date (month/day/year)

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