**BEHAVIORAL HEALTH QUESTIONNAIRE**

Name_____ Age_____ Date_____
Marital Status_____ Occupation_____
Children_____ Who currently lives in your household? _____
_____

Who referred you here, or where did you hear about us? _____

***Present History***

Describe the reason for your visit today._____
_____
_____
_____
_____
_____

Are you currently depressed? Yes No
Have you had past episodes of depression? Yes No
Describe any **current** symptoms that you have regarding the following:
Sleep_____
Appetite_____
Mood/crying spells_____
Irritability/mood swings_____
Anxiety/Panic attacks_____
Energy/Motivation_____
Interest in normal activities_____
Guilt feelings_____
Libido_____
Concentration/Memory_____
Hearing Voices_____
Paranoia_____

Do you presently have suicidal thoughts? Yes No
Have you ever had suicidal thoughts? Yes No
Have you ever attempted suicide? Yes No
Do you or have you had homicidal thoughts? Yes No
Do you have any blood relatives who have committed suicide? Yes No

Please list the current stresses in your life:
_____
_____
_____
_____
_____

Please list your **current psychiatric** medications.
Medication_____Dose_____How long?_____Side effects_____
Medication_____Dose_____How long?_____Side effects_____
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Medication_____Dose_____How long?_____Side effects_____

**(For office use only)**
Accompanied by:_____ _____
HPI: _____

***Past Psychiatric History***

Prior Psychiatrists_____

_____

Past Therapists_____

When/Why?_____

Current Therapist_____

Have you ever been **hospitalized** in the past for any **psychiatric** reasons?
Please list. Include Alcohol or Drug Treatments.

Date_____Place_____Reason_____

Date_____ _ Place_____Reason_____

Date_____Place_____Reason_____

Please List **all psychiatric medications** that you have tried in the past. This includes any medications taken for your nerves, anxiety, depression or insomnia, such as Prozac, Paxil, Zoloft, Celexa, Lexapro, Effexor, Pristiq, Cymbalta, Wellbutrin, Buspar, Remeron,Trazodone, Elavil, Luvox, Xanax, Klonopin, Valium, Ativan, Risperdal, Zyprexa, Seroquel, Abilify, Geodon, Lithium, Depakote, Tegretol, Trileptal, Lamictal, Neurontin, Topamax,Ambien, Lunesta, Rozerem, Restoril, Adderall, Concerta, Ritalin, Focalin, Vyvanse, Strattera, Provigil, Namenda, Aricept.

| Medication and dosage | When/ How long? | Did it help? | Reason for stopping or side effects |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Are you frequently nervous or anxious? Yes No

Are you a worrier? Yes No

Do you have panic attacks or hyperventilation? Yes No

Have you had panic attacks in the past? Yes No

Have you had a fear of objects or situations? Yes No

Do you do a lot of hand washing or going back and checking doors, stoves, lights, etc? Yes No

Are you bothered by recurrent nightmares or flashbacks from a previous traumatic event? Yes No

How much alcohol do you drink? (quantitate)_____per_____

Are alcohol or drugs currently a problem? Yes No

Has alcohol or drugs ever been a problem? Yes No

Have you ever had a DUI or blackout? Yes No

Have loved ones been concerned about your alcohol/drug use? Yes No

Do you have any blood relatives with alcohol/drug problems? Yes No

Have you been arrested? Yes No

Have you had an eating disorder or caused yourself to vomit or lose weight? Yes No

**(For office use only)**

***Medical History***

Please List any medical problems or diagnoses that you have?

_____

_____

_____

_____

_____

Any history of head trauma? Yes No
Any history of seizures? Yes No
Any history of developmental disorders? Yes No
Do you smoke? Yes No
If Yes, how much and for how long?_____
If quit, when?_____
Do you exercise regularly? Yes No

For women:
Do you still have regular periods? Yes No
Do you use birth control? Yes No
Are you taking any hormones? Yes No

**(For office use only)_____**

1. Const neg ___ pos_____
2. Eyesneg ___ pos_____
3. ENT neg ___ pos_____
4. Cardio neg ___ pos_____
5. Resp. neg ___ pos_____
6. GI neg ___ pos_____
7. GU neg ___ pos_____
8. Musc. neg ___ pos_____
9. Skin/Breast neg ___ pos_____
10. Neuro neg ___ pos_____
11. Endo neg ___ pos_____
12. Hem/Lymph neg ___ pos_____
13. Allergies neg ___ pos_____
14. Immune neg ___ pos_____

Please give the name of your primary care doctor
Name_____
Address_____
Phone No._____

Please give the name of any other medical doctor from whom you receive regular treatment
Name_____Specialty_____
Name_____Specialty_____

Medical/Surgical Hospitalizations:
Date_____ Reason_____
Date_____ Reason_____
Date_____ Reason_____
Date_____ Reason_____

**Please list all current medications:**
Name_____Dose_____Reason taking_____
Name_____Dose_____Reason taking_____
Name_____Dose_____Reason taking_____
Name_____Dose_____Reason taking_____
Name_____Dose_____Reason taking_____
Name_____Dose_____Reason taking_____
Name_____Dose_____Reason taking_____
Name_____Dose_____Reason taking_____
Name_____Dose_____Reason taking_____
Name_____Dose_____Reason taking_____

Are you allergic to any medications? Yes No
Medication_____Reaction_____
Medication_____Reaction_____
Medication_____Reaction_____

***Family/Social History***

**(For office use only)_____**

Who in your family has a psychiatric history?
Include history of alcohol or drug problem.
Relationship_____Problem_____
Relationship_____Problem_____
Relationship_____Problem_____
Relationship_____Problem_____

Social History:
Where were you born and raised?_____
Were you raised by your biological parents? Yes No
If no, describe_____
_____
_____
Do you have siblings? Yes No If so, how many?_____
Significant religious/cultural beliefs_____
Primary emotional sources of support _____
Have you ever been physically, emotionally, or sexually abused? Yes No

Please list any significant losses or deaths in your life:
Date_____Description_____
Date_____Description_____
Date_____Description_____
Date_____Description_____

Education _____
Work History_____
Are you currently married? Yes No If yes, how long? _____
Are you having marital or relationship problems? Yes No
If yes, describe_____
If you have children, do they have any significant psychiatric
or medical problems? Yes No
If Yes, please describe_____

Previous marriages? Yes No If yes, answer below.
When_____How Long_____Reason for divorce/separation_____
When_____How Long_____Reason for divorce/separation_____

**SIGNATURE**:_____**DATE**_____
Patient or Patient's Guardian

**STOP HERE**