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NEW PATIENT INTAKE QUESTIONNAIRE

(Please complete all information)

PSYCHIATRY CENTER OF FREDERICK

Name: _____ **Initial Appointment Date:** _____

PERSONAL

Date of Birth:

What town do you live in? _____

How long have you lived there? _____

Where did you grow up? _____

Who do you live with? ❑Self ❑Parents ❑children ❑Spouse ❑Other

SCHOOL

High School ❑Associate ❑Bachelors ❑Masters/PHD ❑Other

Where did you last go to school? _____

What did you/are you studying? (If applicable)_____

MARITAL STATUS (check closest answer):

❑Single ❑Married ❑Divorced/separated ❑Widowed ❑Live with significant other ❑Other (not listed)

Children(s) First Name: Age:

_____ _____

_____ _____

_____ _____

_____ _____

WORK HISTORY

If currently working:

Employer_____

❑Full time ❑Part time ❑Total hours per week _____

If not working Last time employed: _____

Type of work: _____

MEDICAL HISTORY

Primary Care Doctor _____ When was your last physical _____

Other important doctors:_____

Important Medical conditions: _____

_____

_____

Drug allergies: _____

Current Medications (not including psychiatric meds):

_____

_____

_____

_____

PSYCHIATRIC HISTORY:

Last psychiatrist Name (if applicable): _____

What was the reason you left your last psychiatrist? _____

_____

_____

When (if ever) you were first treated for a psychiatric problem: _____

What was the problem? _____

What diagnoses have you been given (list the ones that you think describes your problem

_____

_____

_____

_____

If you have had psychiatric hospitalizations:

When was the first hospitalization: _____

How many times have you been hospitalized? _____

What were the reasons you were hospitalized? _____

_____

_____

_____

Have you ever left a hospital against medical advice? ❑Yes ❑No

If yes explain: _____

_____

_____

PSYCHIATRIC MEDICATION HISTORY:

Medication	Side effects	Effectiveness	Reason stopped*
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you have thoughts that you would rather be dead? (Put X? on line)

.....|.....|.....|.....|

None rarely often most of the time

If you have recently thought of killing yourself, how have you thought of doing it?

1. _____

2. _____

Have you ever tried to kill yourself? ❑Yes ❑No
If yes when and how? _____

LEGAL

Current legal concerns: _____
Past legal concerns: _____

PAST CONCERNS

Appetite:

0 3 5 7 10
.....|.....|.....|.....|
Very poor Good Too much

Weight gain or loss in the past 3 months _____ pounds

Do you have trouble sleeping too much or too little? _____
Please describe: _____
_____
_____

CURRENT CONCERNS

What is the biggest reason you are seeking help? _____
_____
_____
_____
What are other important concerns? _____
_____
_____

What are the biggest stressors in your life (biggest first)?

_____
_____
_____
_____

How much support do you have from family (1-10): _____
Who (Mother, spouse, etc)? _____
How much other support do you have (1-10)? _____
Who (friends, minister, etc): _____

_____

_____

How well are you functioning at home and socially?

0 3 5 7 10

.....|.....|.....|.....|

Very poor Fairly Very well

Major problem at home & socially: _____

_____

_____

How well are you functioning at work or school?

0 3 5 7 10

.....|.....|.....|.....|

Very poor Fairly Very well

Major problem at work or school: _____

_____

_____

What are your goals for treatment (please be as specific as possible)?

1. _____

2. _____

3. _____