



PATIENT HISTORY QUESTIONNAIRE

Date: ____/____/____

NAME: _____ Birthdate: ____/____/____
Last First Middle

Age: _____ Sex: F M

Please read the following questions and answer to the best of your ability by placing a check mark in the appropriate boxes or fill in the blank as directed. YOUR COOPERATION IS APPRECIATED.

How did you hear about this clinic? OR Referred by: _____

PLEASE STATE IN YOUR OWN WORDS WHY YOU HAVE COME TO ALABAMA PSYCHIATRY AND COUNSELING: _____

PSYCHIATRIC HOSPITALIZATIONS (include where, when, & for what reason):
Yes No

- | | | |
|---|-----|----|
| <input type="checkbox"/> Have you ever had ECT? | Yes | No |
| <input type="checkbox"/> Have you had counseling? | Yes | No |

SYSTEMS REVIEW (PSYCHIATRIC)

PLEASE CHECK: In the past month, have you had any of the following problems?

- | | | |
|--|--|--|
| <input type="checkbox"/> Felt sad or low? Sensitivity or Frequent crying? | <input type="checkbox"/> Had felt more self confident? | <input type="checkbox"/> Exposed to a significant traumatic event? |
| <input type="checkbox"/> Felt upset or annoyed at little things? | <input type="checkbox"/> Had felt more energetic and more active then usual? | <input type="checkbox"/> Had recurrent distressing dreams / nightmares? |
| <input type="checkbox"/> Had trouble enjoying things that used to be fun? | <input type="checkbox"/> Had racing thoughts (thoughts jump from topic to topic)? | <input type="checkbox"/> Felt jumpy or easily startled by noises? |
| <input type="checkbox"/> Worried that you might hurt yourself or felt like you wanted to die? | <input type="checkbox"/> Had taken more risks in your daily life? Work? or Other Activities? | <input type="checkbox"/> Felt emotionally distant from others? |
| <input type="checkbox"/> Had felt bad about yourself or that you are a failure or have let yourself or your family down? | <input type="checkbox"/> Felt driven to perform certain acts over and over, such as excessive checking, counting or arranging objects? | <input type="checkbox"/> Bothered by thoughts or images that repeatedly enter your mind such as concerns with contamination or keeping objects in perfect order? |
| <input type="checkbox"/> Felt Hopeless or Worthless? | <input type="checkbox"/> Felt more nervous and anxious than usual? | <input type="checkbox"/> Hear voices or sounds that others do not hear? |
| <input type="checkbox"/> Had trouble falling or staying asleep? | <input type="checkbox"/> Worrying too much about different things? | <input type="checkbox"/> See things that others do not see? |
| <input type="checkbox"/> Sleeping too much? | <input type="checkbox"/> Unable to stop worrying? | <input type="checkbox"/> Smell things others don't smell? |
| <input type="checkbox"/> Had no appetite or been eating too much? | <input type="checkbox"/> Had trouble relaxing? | <input type="checkbox"/> Paranoid or suspicious? |
| <input type="checkbox"/> Felt more tired than usual or have less energy? | <input type="checkbox"/> Felt like you are falling apart and going to pieces? | <input type="checkbox"/> Felt paranoid or suspicious such as being plotted against, followed or monitored? |
| <input type="checkbox"/> Trouble thinking, concentrating or making decisions? | <input type="checkbox"/> Anxiety in social situation? Social phobia? | <input type="checkbox"/> Memory problems / Forgetfulness? |
| <input type="checkbox"/> Moving or speaking so slowly that other people have noticed? | <input type="checkbox"/> I don't like my body? | <input type="checkbox"/> Use of drugs? |
| <input type="checkbox"/> Felt fidgety or restless that you have been moving around a lot more than usual? | <input type="checkbox"/> Intense fear of gaining weight? | <input type="checkbox"/> Abuse of Alcohol? |
| <input type="checkbox"/> Felt like you have no one to talk to? | <input type="checkbox"/> Excessive fasting to loose weight? | <input type="checkbox"/> Smoke cigarettes? |
| <input type="checkbox"/> Sexual problems? | <input type="checkbox"/> Binge eating? | |
| <input type="checkbox"/> Gender concerns? | <input type="checkbox"/> Self-induced vomiting? | |
| <input type="checkbox"/> Difficulties with sexual arousal? | <input type="checkbox"/> Laxative abuse? | |

SYSTEMS REVIEW (MEDICAL)

In the past month, have you had any of the following problems?

GENERAL

- Recent weight gain; how much _____
- Recent weight loss: how much _____
- Fatigue
- Weakness
- Fever
- Night sweats

NERVOUS SYSTEM

- Headaches
- Dizziness
- Fainting or loss of consciousness
- Numbness or tingling
- Memory loss
- Seizure

HEART AND LUNGS

- Chest Pain
- Palpitations
- Shortness of breath
- Fainting
- Swollen legs and feet

MUSCLE/JOINTS/BONES

- Numbness
- Joint pain
- Muscle weakness
- Joint swelling

Where?

STOMACH AND INTESTINES

- Nausea
- Heartburn
- Stomach pain
- Vomiting
- Yellow jaundice
- Increasing constipation
- Persistent diarrhea
- Blood in stools
- Black stools

KIDNEY / BLADDER

- Frequent urination
- Burning on urination
- Blood in urine

WOMEN ONLY

- Abnormal papsmear
- Irregular periods
- Bleeding between periods
- PMS

EARS

- Ringing in ears
- Loss of hearing

EYES

- Pain
- Redness
- Loss of vision
- Double or blurred vision
- Dryness

SKIN

- Redness
- Rash
- Nodules/bumps
- Hair loss
- Color changes of hands or feet

OTHER PROBLEMS

-
-
-
-
-
-
-
-
-
-

THROAT

- Frequent sore throats
- Hoarseness
- Difficulty in swallowing
- Pain in jaw

BLOOD

- Anemia
- Clots
- Excessive Bleeding

PAST MEDICAL HISTORY

Do you now or have you ever had:

- | | | |
|--|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Crohn's disease |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Colitis |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Pulmonary embolism | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Asthma | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Goiter | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Cancer (type) _____ | <input type="checkbox"/> Stroke | <input type="checkbox"/> Stomach or peptic ulcer |
| <input type="checkbox"/> Leukemia | <input type="checkbox"/> Epilepsy (seizures) | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Kidney stones | |

Other medical conditions (please list):

PERSONAL HISTORY

Do you now or have you ever had:

Where were you born & raised?

What is your highest education? High school Some college College graduate Advanced degree

Marital status: Never married Married Divorced Separated Widowed Partnered/significant other

What is your current or past occupation?

Are you currently working? : Yes No

Hours/week _____ If not, are you retired disabled sick leave?

Do you receive disability or SSI? Yes No If yes, for what disability & how long? _____

Have you ever had legal problems? (specify)

CURRENT MEDICATIONS

Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:

Name of drug	Dose (strength & number of pills per day)	How long have you been taking this?

DRUG ALLEGIES

Drug allergies: No Yes To what?

PAST MEDICATIONS

Have you ever been on any of the following medications?

ANTIDEPRESSANTS

- Amitriptyline (Elavil)
- Nortiptyline
- Imipramine
- Clomipramine (Anafranil)
- Desipramine
- Doxepin
- Amoxapine
- Fluoxetine (Prozac)
- Citalopram (Celexa)
- Escitalopram (Lexapro)
- Paroxetine (Paxil)
- Sertraline (Zoloft)
- Fluvoxamine (Luvox)
- Venlafaxine (Effexor)
- Desvenlafaxine (Pristiq)
- Duloxetine (Cymbalta)
- Vortioxetine (Brintellix)
- Vilazodone (Viibryd)
- Bupropion (Wellbutrin)
- Mirtazapine (Remeron)
- Phenelzine (Nardil)

MOOD STABILIZERS

- Valproic Acid (Depakote)
- Lamotrigine (Lamictal)
- Carbamazepine (Tegretol)
- Oxcarbazepine (Trileptal)
- Topiramate (Topamax)
- Gabapentin (Neurontin)
- Lithium

ANXIETY MEDICATIONS

- Alprazolam (Xanax)
- Clonazepam (Klonopin)
- Lorazepam (Ativan)
- Diazepam (Valium)
- Chlordiazepoxide (Librium)
- Oxazepam (Serax)
- Hydroxyzine (Vistaril)
- Buspirone (Buspar)
- Pregabalin (Lyrica)

ANTIPSYCHOTICS

- Risperidone (Risperdal)
- Quetiapine (Seroquel)
- Olanzapine (Zyprexa)
- Ziprasidone (Geodon)
- Clozapine (Clozaril)
- Aripiprazole (Abilify)
- Paliperidone (Invega)
- Asenapine (Saphris)
- Iloperidone (Fanapt)
- Cariprazine (Vraylar)
- Brexpiprazole (Rexulti)
- Haloperidol (Haldol)
- Fluphenazine (Prolixin)
- Pimozide (Orap)
- Chlorpromazine (Thorazine)
- Perphenazine (Trilafon)
- Thioridazine
- Thiothixene (Navane)
- Trifluoperazine (Stelazine)

ADHD MEDICATIONS

- Adderall
- Vyvanse
- Dexedrine
- Methylphenidate (Ritalin)
- Concerta
- Focalin
- Adzenys XR (Amphetamine)
- Metadate (Methylphenidate)
- Bupropion (Wellbutrin)
- Atomoxetine (Strattera)
- Clonidine (Catapres)
- Guanfacine (Tenex; Intuniv)

SLEEP MEDICATIONS

- Trazodone
- Zolpidem (Ambien)
- Zaleplon (Sonata)
- Eszopiclone (Lunesta)
- Ramelteon
- Triazolam (Halcion)
- Temazepam (Restoril)

SUBSTANCE USE TREATMENT

- Methadone
- Buprenorphine (Subutex)
- Disulfiram (Antabuse)
- Naltrexone (Vivitrol)
- Bupropion (Zyban)
- Varenicline (Chantix)
- Acamprosate (Campra)

SUBSTANCE USE

DRUG CATEGORY	Do you currently use this?	Comments
ALCOHOL	Yes <input type="checkbox"/> No <input type="checkbox"/>	
CANNABIS: Marijuana, hashish, hash oil	Yes <input type="checkbox"/> No <input type="checkbox"/>	
STIMULANTS: Cocaine, crack	Yes <input type="checkbox"/> No <input type="checkbox"/>	
STIMULANTS: Methamphetamine—speed, ice, crank	Yes <input type="checkbox"/> No <input type="checkbox"/>	
AMPHETAMINES/OTHER STIMULANTS: Ritalin, Benzedrine, Dexedrine	Yes <input type="checkbox"/> No <input type="checkbox"/>	
BENZODIAZEPINES/TRANQUILIZERS: Valium, Librium, Halcion, Xanax, Diazepam, “Roofies”	Yes <input type="checkbox"/> No <input type="checkbox"/>	
SEDATIVES/HYPNOTICS/BARBITURATES: Amytal, Seconal, Dalmane, Quaalude, Phenobarbital	Yes <input type="checkbox"/> No <input type="checkbox"/>	
HEROIN	Yes <input type="checkbox"/> No <input type="checkbox"/>	
STREET OR ILLICIT METHADONE	Yes <input type="checkbox"/> No <input type="checkbox"/>	
OTHER OPIOIDS: Tylenol #2 & #3, 282’S, 292’S, Percodan, Percocet, Opium, Morphine, Demerol, Dilaudid	Yes <input type="checkbox"/> No <input type="checkbox"/>	
HALLUCINOGENS: LSD, PCP, STP, MDA, DAT, mescaline, peyote, mushrooms, ecstasy (MDMA), nitrous oxide	Yes <input type="checkbox"/> No <input type="checkbox"/>	
INHALANTS: Glue, gasoline, aerosols, paint thinner, poppers, rush, locker room	Yes <input type="checkbox"/> No <input type="checkbox"/>	
OTHER: specify) _____ _____	Yes <input type="checkbox"/> No <input type="checkbox"/>	

FAMILY HISTORY

Please list all blood relatives who have been diagnosed with the following conditions:

Depression / Major Depression / Suicide

Anxiety Disorders

Bipolar Disorders

Schizophrenia / Schizoaffective Disorder / Psychotic Disorders

Alcoholism

Drug Abuse

Heart disease, high blood pressure, arrhythmias

Diabetes

Seizure

Stroke

Thyroid Disorders

Cancer

OTHER
