



New Patient Background Questionnaire

Patient Name _____ Date of Birth _____ Gender _____

Marital Status _____ Number of Children _____

If Patient is a minor, who has legal guardianship: (check one)

___ Both biological parents living in the home with the child

___ Both biological parents have joint custody, but parents are divorced or separated

___ Only one parent has custody – name of custodial parent _____

___ Other custodial arrangement – please describe _____

Referral source _____

Reason for seeking treatment _____

Prior outpatient mental health treatment history (include any treatment from psychiatrists, psychiatric nurses, therapists, etc):

Dates of treatment

Name of Provider

Prior inpatient mental health treatment (include hospital admissions and partial hospitalization programs)

Dates of treatment

Name of Provider

Please describe any history of substance abuse problems and/or treatment:

Please list all medications currently prescribed for the patient (include both psychiatric and non-psychiatric medications):

Name	Dose/Instructions	Prescriber
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>

Please list all psychiatric medications taken in the past that have been discontinued:

Please list any medication allergies: _____

Has any member of the patient's family, including extended family, had mental health problems or treatment and/or substance abuse problems or treatment?

_____ Yes

_____ No

If yes, please provide details below:

Please list history of medical problems and surgical procedures:

Please list any history of trauma or abuse the patient has experienced (complete only if you feel comfortable providing this information on this form):

Please list any current significant sources of stress in the patient's life:

Use the following scale to describe how often the following statements apply to the patient:

0 = Never 1 = Rarely 2 = Occasionally 3 = Frequently 4 = Almost Always

- | | |
|--|--|
| _____ Feeling sad | _____ Decreased interest or pleasure in usual activities |
| _____ Appetite change | _____ Sleep problems or changes |
| _____ Decreased level of energy | _____ Thoughts of death or suicide |
| _____ Thoughts about self-injury | _____ Increased energy level |
| _____ Racing or hard to track thought pattern | _____ Decreased amount of sleep without feeling tired |
| _____ Being easily distracted | _____ Increased level of activities |
| _____ Impulsive behaviors | _____ Feeling anxious or nervous |
| _____ Obsessive thoughts | _____ Repetitive or compulsive behaviors |
| _____ Recall of past traumatic events | _____ Being easily startled |
| _____ Eating too much or too little | _____ Hearing voices or seeing things others can't |
| _____ Fears that people will or may want to harm you | |