



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 psychiatrist, 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 medication currently prescribed for the patient (include both psychiatric and non-psychiatric medications):

Name	Dose/Instructions	Prescriber
<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

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