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INITIAL QUESTIONNAIRE

NAME:_______________________________________ **AGE**______ **DATE**______
GENDER M/F __________________ **MARITAL STATUS** _S_M_D_W
SCHOOL (GRADE)/ WORK ___________________________ **D.O.B**________
How were you referred to us ? :____
Reason for today's visit:____
____

Please answer / put a check mark against all the questions that apply :

Have you experienced the following in the past (MOOD CHANGES) ? ____Yes ___No

_____Sad/ depressed
_____Low self esteem
_____Guilt feelings
_____Sleep disturbance
_____Appetite increase or decrease
_____change in Energy level
_____ Reduced Concentration
_____Irritability
_____Physical problems (eg headaches, stomaches)
_____Motivation/ lack of interest in things that you usually enjoy
_____wt. change (gain) (decrease)
_____Elevated / euphoric mood
_____Grandiosity/inflated self-esteem
_____Rapid speech/ racing thoughts
_____Reduced need for sleep
_____Irritability
_____Excess goal directed activity
_____Distractibility/ reduced concentration
_____Impulsivity (sexual / financial)
_____Poor judgment/ planning
_____**Any thoughts of Suicide** _____**Any Suicide attempts / self mutilation**

____
____
____
____

Any problems wih ATTENTION span, distractibility, poor organization, hyperactivity, Impulsivity
____Yes ____No____
____
____
____
____

Any TRAUMA in the past (such as): ____Yes _____No
_____Physical Abuse____ Sexual Abuse____Emotional Abuse____Accidents
____
____

Any Problems with Your SLEEP ? ___Yes __No ____________________________
Any Fears or Phobias / ANXIETY Problems : __Yes __No
_____Excessive hand washing, excessive need for organization / perfection / checking , persistent thoughts
_____Fear of speaking in front of others / groups, fear of social situations
_____Fears or Phobias eg Fear of heights, elevators, closed spaces,
_____Sudden severe anxiety, fear of death, physical symptoms_______________
_____Anxiety episodes due to past experiences of trauma or accidents ____________
_____Excessive worry eg about family, finances, health, fear of death____________
_____Refusal to go to school, severe anxiety being away from family, ____________
____
____

Any Diosrganized thoughts, behaviors (PSYCHOTIC Behaviors): ___Yes ___No

_____Any hallucinations ____Change in self care, poor hygiene

_____Fixed , false beliefs ___________ , ____ Abnormal body movements_____________

_____Paranoid thoughts

_____Change in memory, concentration, academic or intellectual decline

_____Strange thoughts/ behaviors ____________________________

Any problems/dependency with ALCOHOL, DRUGS, PRESCRIPTION DRUGS : ___Yes ___No

Any (__DUI's __Blackouts __Seizures __DTs __Head trauma __Legal problems)

____Any use of Inhalants (eg gasoline, paint, aerosol sprays) _____Any use of Intravenous drugs

Use/ Frequency/Last use of Alcohol, Drugs______________________________________

_____ Any treatment in Inpatient Detox/ Rehab __Any participation n Self Help groups (AA/ NA)

_____Any use of Cigarettes _____Any use of Caffeine

Any LEGAL PROBLEMS : ____Yes ___No

_____Current _____Past _____None : _______Any history of Probation

Any problems associated with severe IMPULSIVITY,:. ___Yes ___No

_____Major rage episodes / explosive behaviors _____Stealing

_____ Fire setting episodes _____Excessive Gambling or money spending

_____Hair pulling

Any problems with poor self /body image and / or EATING DISORDER issues : ___Yes ___No

_____Anorexia _____Bulimia _____Binge eating

__Reduced food intake __Poor self (body) image

__Purging __Laxatives etc.

__Abnormal menstrual cycles __Wt. loss_________________________

__Any target wt._______________ __Previous tx.______________________

MEDICAL HISTORY:

Any **ALLERGIES** (food / drug) ___Yes ___No

Any Major Medical Illness(es) (eg Asthma, Diabetes, THYROID gland disorders , High Blood Pressure, Heart Problem , Seizures, Head Injuries) ___Yes ___No_________________________________

Are you PREGNANT (for childbearing age female pts. only) ____No ___ Yes

Please list ALL CURRENT MEDICATIONS and DOSAGE (including over the counter meds /herbal supplements/vitamins/Rx.)____

ANY PREVIOUS PSYCHIATRIC HISTORY (eg ADHD, Depression, Bipolar Disorder, Anxiety Disorders, Schizophrenia, Alcoholism or Drug Addiction) : _____Yes ____No

Outpatient treatment ______

Therapy______

Inpatient treatment or Long term hospitalizations______

Any previous history of violent behavior______

LIST OF PSYCHIATRIC MEDICATIONS IN THEPAST and RESPONSE (including those for treatment of ADHD) : ______

List of all FAMILY MEMBERS at home and their ages :

Any FAMILY MEMBERS (Biologically related) with any PSYCHIATRIC / EMOTIONAL PROBLEMS (eg ADHD, Depression, Bipolar Disorder, Anxiety Disorders, Schizophrenia, Alcoholism or Drug Addiction) : ____Yes ____No

Any Completed SUICIDES in family members ? ____Yes ___No______

Do you AUTHORIZE us to release clinical information to your :

Primary Care Physician (Name / Tel. No.) ___Yes ___No______

Therapist (Name / Tel. No.) : ____Yes ___No ______

Additional Questionnaire for CHILDREN and ADOLESCENTS :

Any BEHAVIOR PROBLEMS characterized by: ____Yes ___No

_____Oppositional
_____Defiant
_____Vindictive
_____Spiteful
_____Makes others angry
_____Is angry easily
_____Aggression
_____Cruelty to animals
_____h/o use of a weapon
_____h/o gang membership
_____destruction of property
_____h/o run away behavior

Any Problems (mother's pregnancy &/ or child's GROWTH & DEVELOPMENT) : ___Yes ___No

Any concerns about any AUTISTIC DISORDERS : ____Yes ___No

__Delay in speech
__Stereotypical behaviors / movements
__Poor social interaction
__Used to routines / rituals
__Communication problems
__Restricted range of activities
__Other dev. Delays

Any concerns about severe MENTAL DEVELOPMENTAL DELAYS : ____Yes ___No

__Very childish or infantile behaviors compared to peers
__Low IQ based on previous testing

SCHOOL ENVIRONMENT and history:

__Reg. Ed. __Sp.Ed. __E.B.D
__h/o Learning disability __h/o School violence __h/o alternative schools

Has PSYCHOLOGICAL TESTING been done in the past ? : ___Yes ___No