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Date \_\_\_\_\_

Last name \_\_\_\_\_ First name \_\_\_\_\_

**Clinical Questionnaire**

(Hand deliver at our first meeting.)

What is the main reason that brings you to see me?

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When did the difficulty begin?

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What factors may have contributed to or caused the difficulty?

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What medication, if any, are you *currently* taking for the main reason that brings you to see me? Note:  
There is room later to list medications for other problems.

Name of medication                      Strength (mgs)                      Schedule (for example, 1 once/day)

<u>Name of medication</u>	<u>Strength (mgs)</u>	<u>Schedule (for example, 1 once/day)</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

In the *past*, what other medication, if any, have you taken for the main problem that brings you to see me? If you can remember the maximum daily dose that you took and how long you were on that dose, that information is of interest. Note: If there is not enough room here, please provide the list on a separate piece of paper.

<u>Name of medication</u>	<u>Max. daily dose (mgs)</u>	<u>How long on max. daily dose</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are there any other recent mental symptoms, intellectual difficulties (for example, memory trouble), or behavioral problems that you would like to bring to my attention?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Circle any item below that occurred during childhood or adolescence:

- Learning disability
- Autism
- Inattentiveness/hyperactivity/impulsiveness
- Serious family problems
- Sexual, physical or emotional abuse
- Other \_\_\_\_\_

List any noteworthy mental health, substance abuse, or sleep-related difficulties you have reason to think you either had in the more-distant past or have had recently but are not described above. (For a selected list of broad categories, see next page.)

<u>Difficulty</u>	<u>Treatment (if any)</u>
_____	_____
_____	_____
_____	_____
_____	_____

List for use responding to the last item on page 2:

Schizophrenia or other psychotic disorder (for example, hallucinations or delusions)

Bipolar disorder, with at least one episode of manic features, such as the following:

- elevated, expansive or irritable mood
- increased goal-directed activity or energy
- inflated self-esteem or grandiosity
- decreased need for sleep
- talkativeness or pressure to keep talking
- racing thoughts or crowded thoughts
- distractibility
- over-activity or agitation
- reckless behavior

Depression

Anxious conditions, such as phobias, excessive social anxiety, panic attacks, or excessive worry about a number of events or activities

Obsessions or compulsions

Preoccupation with perceived defects or flaws in physical appearance

Hoarding, hair pulling, or skin picking

Posttraumatic stress disorder

Eating disorders, such as excessively restrictive food or fluid intake, binge eating, or purging behaviors

Sleep-wake disorders, such as insomnia, sleep apnea, being a “night owl,” or restless legs

Sexual dysfunction

Gender identity concerns

Substance-related disorder—i.e., problematic use of a substance, such as illicit drugs, marijuana, alcohol, or prescription medications

Dementia

Personality or behavioral issues that are enduring and cause either significant distress or impairment in functioning

In your medical history, have you had any of the following? If yes, describe.

Significant childhood illness, injury or surgery	Yes	No
Head trauma with loss of consciousness	Yes	No
Seizures	Yes	No
Narrow angle or angle closure of the eyes, or glaucoma of the eyes	Yes	No
Heart problems	Yes	No
Premenstrual syndrome(females)	Yes	No
Prostate enlargement (males)	Yes	No
Exposure to toxins	Yes	No
Serious injury	Yes	No

Other noteworthy medical conditions in the past that are not now an active problem for which you are getting treatment:

Surgeries

Allergies to medication

Current major medical conditions (for example, diabetes, high blood pressure, heart problem):

<u>Condition</u>	<u>Medication being taken (or other treatment)</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Recently, have you been having noteworthy physical symptoms (for example, pain, fever)?

If so, describe:

Are there any prescription or over-the-counter medications you take regularly or intermittently other than what is listed above? If so, list:

Are there any vitamins, supplements, herbal remedies, or holistic or "complimentary and alternative medicine"-type products you take regularly or intermittently? If so, list:

Have you had blood tests done in the past year? Yes No

Have you had an electrocardiogram (EKG) done in the past 2 years? Yes No

Have you ever had a brain scan? Yes No

If the answer to any of the above questions is yes, please provide a copy of the results or report, if available.

Do you use the following? If so, how much (for example, per day, week or month)?

Alcohol

Caffeinated beverages

Cigarettes

Illicit drugs (for example, cocaine)

Marijuana/cannabis

Prescription drugs (for example, stimulants, narcotics)

Other background information:

Diet: Is it regular or special (for example, vegan)?

Exercise

Leisure activities

Highest grade level or degree achieved

Other background information (continued):

Religious affiliation/spiritual orientation

Military service

Past occupations

Current occupation

Marital history and current marital status

Housing situation (for example, live in own home)

Family history

For blood relatives--including grandparents, parents, aunts/uncles, siblings and children--list any noteworthy mental health or substance abuse disorder or difficulty, with treatment received.

<u>Family member (e.g., father)</u>	<u>Disorder or difficulty</u>	<u>Treatment</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

For blood relatives, list any major medical conditions (for example, heart disease), sleep disorders (for example, being a "night owl," restless legs), or neurological conditions (for example, dementia) that seem to run in the family:

<u>Family member (e.g., mother)</u>	<u>Condition or disorder</u>	<u>Treatment</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Any additional comments?

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