Texas Tech University Health Sciences Center

PATIENT INTAKE QUESTIONAIRE

Psychiatry Clinic

Identifying Data, Chief Complaint, History of Present Illness:

Date_____ Name _____ Age ____ Marital Status _____ Race _____ Sex: _____
Occupation _____ Place of Employment_____
Who else lives in your household? _____

Chief Complaint:
Why are you requesting an evaluation? _____

Past Psychiatric History:

1. List all previous psychiatric hospitalizations in the past:

Name of Hospital	Dates	Length of Stay	Diagnosis / reason for admission	Medications / Treatments

2. List all outpatient treatment for psychiatric problems in the past:

Name of Clinic/Agency/Doctor	Location	Dates	Problems Treated	Names of psychiatric medications

When did you first start having psychiatric symptoms? _____ Please describe your past episodes and how your symptoms have changed since you first had problems: _____

Have you ever attempted suicide? _____ If so, how many times? _____ How? _____
When?

Please list all psychiatric medications you have taken in the past (as well as you can remember):

Medication	Highest dose taken:	Dates/How Long?	How much did it help?	Any Negative Affects?
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

Current, Most Recent Episode:

Please describe your current episode. When did it start? Were there any stresses that may have contributed? What kind of symptoms have you been experiencing? Have you had any treatments for this episode? If so, how have you responded to these treatments?_____

Current Psychiatric Medications:	Dose:	Date Started:	Prescribed by:
1.			
2.			
3.			
4.			
5.			

Bio-Psycho-Social Background:

Family History Among your blood relatives has there ever been any: psychiatric hospitalizations, depression, schizophrenia, suicide, bipolar (manic depression), anxiety disorders, alcohol problems, drug abuse, arrests, prison, mental retardation, learning disorders, or other disorders (please describe)? Include children, siblings, parents,(great) aunts & uncles, (great)grandparents, 1st & 2nd cousins

Relationship	Age	Diagnosis/symptoms	Hospitalizations/Treatment

Development, Childhood, School

Describe any problems with your birth/infancy:_____

Were you delayed, slow in learning to walk, talk or be toilet trained? Yes ____ No ____

Did you have to repeat any grades in school? No___ Yes___ (which ones?_____) Were you in special ed or resource classes? No ___ Yes ___ (which school years/subjects? _____) Highest educational level:_____

Describe any emotional or behavior problems as a child/teen: _____

Abuse/Trauma Please describe any abuse or severe emotional trauma you have experienced in your life:_____

Neurological History Please describe any severe head injuries, episodes of coma or unconsciousness, strokes, meningitis or encephalitis, or other neurological illnesses: _____

Substance Abuse List all drug/alcohol rehab treatment and detox in the past:

Name of Program	Location	Dates	Length of Treatment	What substances were you using?

Have you ever been arrested for: DWI, PI, Possession, other? _____ No. of times_____

Alcohol: How often do you drink alcohol? _____ How much do you drink? _____

Have you ever felt that you ought to cut down on your drinking? _____ Have you felt annoyed by others who criticize your drinking? _____Have you ever felt bad or guilty about your drinking? _____ Have you ever had a drink early in the morning to steady your nerves or get rid of a hangover? _____ Have you ever not remembered what you did while you were drinking?_____ Have you had any of the following after you stopped drinking? Shakes ____ Seizures ____ Hallucinations _____ DT's____

Nicotine: Do you smoke? _____ How many packs?_____ Do you dip/chew tobacco?_____ How much?_____

How long have you used tobacco?_____ How many times have you tried to quit?_____

Street or prescription drugs: List the street drugs you have used (speed, crank, amphetamines, uppers, downers, coke, cocaine, crack, heroin, LSD, psychedelic mushrooms, marijuana, pot, glue, other huffing, has, opium,, etc). Also list prescription drugs you have abused (sleeping pills, narcotics/opiods, pain pills, barbiturates, Valium, Xanax, Ativan, muscle relaxants, methadone, steroids, etc.)

Name of drug	Age Began	Last Used	How used (snorted, smoked, IV, by mouth, etc)

Do you attend AA or NA?_____ Do you have a sponsor? _____ What's the longest sobriety you have ever had? _____

Legal History Please describe any legal problems: _____

_____On Probation?____ Parole? _____ PO's Name:_____

Past Arrests/Convictions (describe)	Date	Status	Location

Marital/Occupational How many times have you been married? _____ Please list names/ages of children:_____

What kinds of work have you done in the past? _____

Have you had any occupational problems?_____

Medical Please list all previous surgeries and approximate dates: _____

Describe all medical conditions from which you suffer: _____

Medication ALLERGIES: _____

List all medications from other physicians	Condition for which you take it	Doctor/provider

Women only? LMP _____ Birth Control? _____ Any chance currently pregnant/intent to get pregnant?_____

PLEASE CHECK HERE IF ANY ADDITIONAL INFORMATION ON THE BACK OF THIS PAGE _____

ADDITIONAL INFORMATION YOU WANT THE DOCTOR OR NURSE TO KNOW ABOUT: