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**

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