Patient name			
MHN	DOB	Age	Gender

Adult

Psychiatric/MH Questionnaire

Preferred language _____

Special or disability needs _____

Appointment date (m/d/y) _____ /_____ /_____ Form completed by: ☐ Self ☐ Other (specify) _____

Your preference for how to best contact you _____

Who referred you _____

Primary care provider _____

Briefly describe the history of your problem and what you have tried to do about it so far

_____

_____

_____

_____

_____

_____

_____

Treatment goals _____

Treatment preferences _____

Personal strengths _____

Place one check (✓) next to those items that are of concern to you. Place two checks (✓ ✓) next to those items which are causing you the greatest difficulty:

- ☐ ☐ Depressed mood
- ☐ ☐ Crying spells
- ☐ ☐ Lack of energy/interest/motivation
- ☐ ☐ Suicidal thoughts
- ☐ ☐ Social withdrawal/loneliness/ feeling disconnected
- ☐ ☐ Anxiety/Stress/Nervousness
- ☐ ☐ Panic attacks (chest pain, heart racing sweating, shortness of breath lasting10 minutes or more)
- ☐ ☐ Worrying
- ☐ ☐ Fears
- ☐ ☐ Difficulty concentrating
- ☐ ☐ Increased irritability or anger
- ☐ ☐ Past trauma
- ☐ ☐ Recurrent thoughts about past events
- ☐ ☐ Nightmares about past events
- ☐ ☐ Obsessive thoughts/behaviors
- ☐ ☐ Seeing/Hearing things others do not see
- ☐ ☐ Addictions (alcohol, drug, gambling)
- ☐ ☐ Work/School difficulties
- ☐ ☐ Loss/Grief/Death
- ☐ ☐ Preoccupation with weight
- ☐ ☐ Decreased sexual interest
- ☐ ☐ Headaches
- ☐ ☐ Snoring

Adult

Psychiatric/MH Questionnaire (Continued)

Patient name	MHN	DOB	Age	Gender

Psychiatric and/or addiction history

Do you currently have a psychiatrist, psychologist, social worker or counselor: ☐ Yes ☐ No

Name(s) of current mental health providers _____

Past outpatient mental health and/or addiction treatment:

Date of Service	Name of Provider	Clinic/Location Name

Psychiatric and/or addiction hospitalizations:

Date of Hospitalization	Involuntary or Voluntary	Hospital/Location Name

Have you ever had electroconvulsive therapy (ECT): ☐ Yes ☐ No

Self-injury

Have you ever injured yourself on purpose: ☐ Yes ☐ No

Suicide

Have you ever attempted suicide: ☐ Yes ☐ No

Addictive behavior

Gambling

Do you have difficulty controlling your gambling: ☐ Yes ☐ No

Tobacco/Nicotine

Have you ever used tobacco: ☐ Yes ☐ No

Caffeine

Daily use: ☐ None ☐ 1 – 3 servings per day ☐ 4 – 6 servings per day ☐ 6 or more servings per day

Alcohol

How often are you using alcohol:

☐ Monthly or less ☐ 2 – 3 times per week ☐ 2 – 4 times per month ☐ 4 or more times per week

Patient name	MHN	DOB	Age	Gender

Drugs used:

- ☐ LSD
- ☐ PCP
- ☐ Barbiturates
- ☐ Cocaine
- ☐ Cough syrup
- ☐ Ecstasy
- ☐ Heroin
- ☐ Inhalants
- ☐ Marijuana
- ☐ Methamphetamines
- ☐ Mushrooms
- ☐ Prescription controlled substances
- ☐ Opiates

Medications

If you are not a Marshfield Clinic Health System patient check (✓) any of the following that you have taken:

Antipsychotic:

- ☐ ChlorproMAZINE (Thorazine®)
- ☐ Fluphenazine HCl (Prolixin®)
- ☐ Haloperidol (Haldol®)
- ☐ Loxapine succinate (Loxitane®)
- ☐ Mesoridazine (Serentil®)
- ☐ Perphenazine (Trilafon®)
- ☐ Pimozide (Orap®)
- ☐ Thioridazine (Mellaril®)
- ☐ Thiothixene (Navane®)
- ☐ Trifluoperazine (Stelazine®)

Atypical antipsychotic:

- ☐ ARIPiprazole (Abilify®)
- ☐ Asenapine sublingual (Asaphris®)
- ☐ CloZAPine (Clozaril®)
- ☐ Iloperidone (Fanapt®)
- ☐ Lurasidone (Latuda®)
- ☐ OLANZapine (ZyPREXA®)
- ☐ Paliperidone (Invega®)
- ☐ QUEtiapine (SEROquel®)
- ☐ RisperiDONE (Risperdal®)
- ☐ ZiprasidoneHCl (Geodon®)

Benzodiazepine:

- ☐ ALPRAZolam (Xanax®)
- ☐ Chlordiaze HCl (Librium®)
- ☐ ClonazePAM (KlonoPIN®)
- ☐ DiazePAM (Valium®)
- ☐ LORazepam (Ativan®)
- ☐ Temazepam (Restoril®)

Central nervous system agent:

- ☐ CloNIDine HCl (Catapres®)
- ☐ Donepezil (Aricept®)
- ☐ Galatamine hydrobromide (Razadyne®)
- ☐ GuanFACINE (Intuniv®)
- ☐ GuanFACINE (Tenex®)
- ☐ Memantine (Namenda®)
- ☐ Prazosin (Minipress®)
- ☐ Rivastigmine (Exelon®)

Extrapyramidal symptoms side effect:

- ☐ Benztropine (Cogentin®)
- ☐ Trihexyphenidyl (Artane®)

Monoamine oxidase inhibitor antidepressant:

- ☐ Phenelzine (Nardil®)
- ☐ Tranylcypromine sulfate (Parnate®)

Mood stabilizer and anticonvulsant:

- ☐ CarBAMezepine (TEGretol®)
- ☐ Divalproex (Depakote®)
- ☐ LamoTRIgine (LaMICtal®)
- ☐ Lithium carbonate (Eskalith CR®)
- ☐ OXcarbazepine (Trileptal®)
- ☐ Topiramate (Topamax®)

Non-barbiturate hypnotic:

- ☐ Chloral hydrate (Somnote®)
- ☐ Eszopiclone (Lunesta®)
- ☐ Ramelteon (Rozerem®)
- ☐ Zaleplon (Sonata®)
- ☐ Zolpidem (Ambien®)

Non-benzodiazepine:

- ☐ BusPIRone (BuSpar®)
- ☐ Gabapentin (Neurontin®)
- ☐ HydrOXYzine pamoate (Vistaril®)
- ☐ TiaGABine (Gabitril®)

Patient name	MHN	DOB	Age	Gender

Non-SSRI antidepressant:

- ☐ BuPROPion HCl (Wellbutrin®)
- ☐ Desvenlafaxine succinate (Pristiq®)
- ☐ DULoxetine (Cymbalta®)
- ☐ Fluvoxamine (Luvox®)
- ☐ Mirtazapine (Remeron®)
- ☐ TraZODone (Desyrel/Oleptro®)
- ☐ Venlafaxine (Effexor XR®)
- ☐ Vilazodone (Viibryd®)

SSRI antidepressant:

- ☐ Citalopram (CeleXA®)
- ☐ Escitalopram (Lexapro®)
- ☐ FLUoxetine (PROzac®)
- ☐ Fluvoxamine (Luvox®)
- ☐ Fluvoxamine maleate (Luvox®)
- ☐ OLANZapine-FLUoxetine HCl (Symbyax®)
- ☐ PARoxetine HCl (Paxil®)
- ☐ Sertraline (Zoloft®)

Stimulants:

- ☐ Amphetamine/Dextroamphetamine (Adderall®)
- ☐ Armodafinil (Nuvigil®)
- ☐ Atomoxetine (Strattera®)
- ☐ Dexmethylphenidate (Focalin®)
- ☐ Dextroamphetamine (Dexedrine®)
- ☐ Lisdexamfetamine (Vyvanse®)
- ☐ Methylphenidate HCl (Ritalin®/Concerta®)
- ☐ Modafinil (Provigil®)

Substance dependency:

- ☐ Acamprosate (Campral®)
- ☐ Disulfiram (Antabuse®)
- ☐ Naltrexone (Revia®)

Tricyclic antidepressant:

- ☐ Amitriptyline (Elavil®)
- ☐ Amoxapine (Asendin®)
- ☐ Clomipramine (Anafranil®)
- ☐ Desipramine (Norpramin®)
- ☐ Doxepin (Sinequan®)
- ☐ Imipramine (Tofranil®)
- ☐ Maprotiline (Ludiomil®)
- ☐ Nortriptyline (Pamelor®)
- ☐ Protriptyline (Vivactil®)

Personal medical history

Date of last physical evaluation _____ Physical pain concern: ☐ Yes ☐ No

Check (✓) any of the following that you have experienced:

- ☐ Meningitis
- ☐ Encephalitis
- ☐ Seizure/Convulsion
- ☐ Tubes placed in ears
- ☐ Pneumonia
- ☐ Asthma
- ☐ Heart disease/problem
- ☐ Nervous twitches or tics
- ☐ Tremor
- ☐ Lead poisoning
- ☐ Recurrent headaches/stomach aches
- ☐ Severe injuries or broken bones
- ☐ Hearing problems
- ☐ Vision problems
- ☐ Head injuries

Nutritional assessment:

Food allergies	☐ Yes	☐ No
Weight loss/gain of 10 or more pounds	☐ Yes	☐ No
Decrease in food intake and/or appetite	☐ Yes	☐ No
Binge eating	☐ Yes	☐ No
Self induced vomiting	☐ Yes	☐ No
Intentional restriction of food intake	☐ Yes	☐ No
Dental problems	☐ Yes	☐ No
Diuretics/Laxatives	☐ Yes	☐ No
Excessive exercise	☐ Yes	☐ No

Psychiatric/MH Questionnaire (Continued)

Patient name	MHN	DOB	Age	Gender

Hospitalizations/Operations	Age	Description

Allergies: ☐ Yes ☐ No

If yes, specify _____

Do you have a history of accidents, head injuries, seizures and blackouts: ☐ Yes ☐ No

If yes, what happened _____ Date _____

Do you have a history of sexually transmitted disease (gonorrhea, chlamydia, syphilis, hepatitis B or C, HIV): ☐ Yes ☐ No

OB/GYN (females only)

Number of pregnancies _____ Number of miscarriages _____

Number of living children _____ Last menstrual period _____

Method of birth control (abstinence, condoms, Essure®, Nexplanon®, diaphragm, Depo-Provera®, estrogen patch, hysterectomy, IUD, natural family planning, none, planning to conceive, oral birth control, partner vasectomy, same sex relationship, tubal ligation or post-menopausal) _____

7 – 10 days before your period, do you experience any of the following:

☐ Bloating ☐ Breast tenderness ☐ Food craving ☐ Increased appetite ☐ Irritability
☐ Cramps ☐ Sleeping problems ☐ Weight gain ☐ Increased depression

Mood changes with cycle or with birth control: ☐ Yes ☐ No

If yes, was birth control being used at the time: ☐ Yes ☐ No

Family history of medical and psychiatric illnesses

Diagnosis	Yes/No	Who (parent, grandparent, sibling)
Dementia	☐ Yes ☐ No	
Developmental disabilities	☐ Yes ☐ No	
Diabetes	☐ Yes ☐ No	
Heart disease/hypertension	☐ Yes ☐ No	
Thyroid problems	☐ Yes ☐ No	
Tourette syndrome or tics	☐ Yes ☐ No	
Anxiety	☐ Yes ☐ No	
Attention deficit hyperactivity disorder (ADHD)	☐ Yes ☐ No	

Psychiatric/MH Questionnaire (Continued)

Patient name	MHN	DOB	Age	Gender

Diagnosis	Yes/No	Who (parent, grandparent, sibling)
Bipolar/Mania	☐ Yes ☐ No	
Complete/Attempted suicide	☐ Yes ☐ No	
Depression	☐ Yes ☐ No	
Electroconvulsive therapy	☐ Yes ☐ No	
Eating disorder	☐ Yes ☐ No	
Obsessive compulsive disorder	☐ Yes ☐ No	
Panic disorder	☐ Yes ☐ No	
Paranoia	☐ Yes ☐ No	
Schizophrenia	☐ Yes ☐ No	
Violence	☐ Yes ☐ No	
Alcohol/Drug abuse/dependence	☐ Yes ☐ No	
Other	☐ Yes ☐ No	

Social history

Physical, emotional, sexual or verbal abuse..... ☐ Yes ☐ No
Neglect or exposure to violence..... ☐ Yes ☐ No

Significant trauma (ie. loss of loved one, MVA): _____

Who lives with you now in your household _____

Ethnicity:
☐ White ☐ African American ☐ Native American ☐ Hispanic ☐ Asian ☐ Middle Eastern
☐ Other _____

Do you consider yourself to be:
☐ Heterosexual or straight ☐ Gay or lesbian ☐ Bisexual ☐ Not sure/questioning
☐ Other _____

What is your current gender identity:
☐ Male ☐ Female ☐ Trans male/trans man ☐ Trans female/trans woman
☐ Gender queer/gender non-conforming ☐ Different identity (please state) _____

Preferred pronoun:
☐ She/Her ☐ He/Him ☐ They/Them
☐ Other _____

Sex assigned at Birth:
☐ Male ☐ Female
☐ Other _____

Adult

Psychiatric/MH Questionnaire (Continued)

Patient name	MHN	DOB	Age	Gender

Relationship status:
☐ Married ☐ Cohabitating ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Partnered
☐ Other _____

Employment status:
☐ Employed full-time ☐ Employed part-time ☐ Unemployed ☐ Disabled ☐ Retired
☐ Homemaker ☐ Other _____

How many children do you have: Biological _____ Adopted _____ Step children _____

Who are your main sources of support _____

Do you have a valid driver's license ..... ☐ Yes ☐ No

Educational history and learning needs

Did you graduate from high school ..... ☐ Yes ☐ No

Post High School education ..... ☐ Yes ☐ No

If yes, degree/certification _____

Academic/Behavioral issues while in school _____

Emotional, motivational, physical, cognitive limitations to learning ..... ☐ Yes ☐ No

If yes, barriers to communication _____

Past intelligence and or neuropsychological/psychological testing ..... ☐ Yes ☐ No

If yes, where _____

Employment or vocational history

Have you ever served in the armed forces ..... ☐ Yes ☐ No

Legal or arrest history

Have you ever been arrested or do you have a legal history ..... ☐ Yes ☐ No

Any history of violent crimes ..... ☐ Yes ☐ No

Are you currently on probation or parole ..... ☐ Yes ☐ No

If yes, name of officer you are working with _____

Other

Hobbies and/or leisure activities _____

Cultural preferences _____

Religious preference _____

Signature/Title _____ Date (m/d/y) ____ /____ /____ Time _____

