Date:

Psychiatric History Questionnaire.
MD TruCare PA
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Website: www.mdtrucare.com

Patient Name: _____DOB: M/D/Y _____Age: _____
Sex: Male:☐/Female: ☐ Occupation:_____

CHIEF COMPLAINT: Please state the principal reason you are requesting a consultation or treatment:

History of Present Problems:

Please describe your illness from the time of onset of your symptoms to the present.
When did your symptoms start?

_____

What were your main symptoms?

Depression☐ Anxiety☐. Suicidal thoughts☐. Loss of interest in activities☐. Psychotic symptoms☐

_____

What were your stressors? Are you going through any major stressors like divorce, relationship issues, work or financial stress?

_____

Over the last two weeks or more, have you noticed the following (for each line, check the box that best applies to you?

	Not at All	Several Days	More Than Half the Days	Nearly Everyday
1. I feel sad, down in the dumps, or unhappy				
2. I can't concentrate or focus				
3. Nothing seems to give me much pleasure				
4. I feel tired; have no energy				
5. I have thoughts of suicide				
6. I have difficulty sleeping				
7. I sleep too much				
8. I have lost some appetite				
9. I am eating more				
10. I feel tense, anxious, or can't sit still				
11. I feel worried or fearful				
12. I have attacks of anxiety or panic				

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13. I worry about dying or losing control				
14. I am nervous in a social situation				
15. I am jumpy or feel startled easily				
16. I avoid places that remind me of a bad experience				
17. I feel dull, numb, or detached				
18. I can't get certain thoughts out of my mind				
19. I feel I must repeat certain acts or rituals				
20. I feel the need to check and recheck things Have you ever noticed the following:				
21. I have more energy than usual				
22. I have felt unusually irritable or angry				
23. I have felt unusually excited, revved up, or high				
24. I have needed less sleep than usual				
25. My mind is playing tricks on me like hearing voices or seeing things which are not around				
26. I feel that there are people who are trying to get me or hurt me				
27. Do you snore or people told you that you snore?				
Indicate whether any of the above symptoms:	**Not at All**	**Several Days**	**More Than Half the Days**	**Nearly Everyday**
28. Interfere with work or school				
29. Affects my relationships with friends or family				
30. Has led to my using alcohol to get by				
31. Has led to my using other substances				

How often do you have a drink containing alcohol?	Never ☐	Monthly or less ☐	2-4 times/ month ☐	2-3 times/ week ☐	4 or more times/ week ☐
How many drinks containing alcohol do you have on a typical day when you are drinking?	1 to 2 ☐	3 to 4 ☐	5 to 6 ☐	7,8, or 9 ☐	10 or more ☐
How often do you have six or more drinks on one occasion?	Never ☐	Less than monthly ☐	Monthly ☐	Weekly ☐	Daily or almost daily ☐
Do you use drugs like the following	marijuana ☐	Cocaine ☐	Opiates ☐	Benzodiazepines ☐	

Previous Mental Health Treatment

Have you ever been hospitalized for a mental illness or substance abuse? Yes☐ No ☐.
If yes, please list below any or all diagnosis given, as well as, date(s) of admission, the name of the hospital or outpatient program facility: _____

_____

Date(s): _____ Hospital: _____
Outpatient Program: Yes ☐ No☐ _____
Alcoholic Anonymous: Yes☐ No☐

Date:

Previous / Current Psychiatrist: _____

Previous Diagnosis:

Depression (Major Depressive Disorder): Yes☐/No☐

Anxiety Disorder (For Example: Panic attacks, Chronic Worry, Social Anxiety, PTSD): Yes☐/ No☐

Bipolar Disorder: Yes☐/No ☐

Psychotic Disorder: Yes☐/No ☐

OCD: Yes☐/No☐

ADHD: Yes☐/No☐

Sleep Disorder: Yes☐/No☐

Eating Disorder: Yes☐/No☐

Current Medications

Please list below any and all medications you are currently taking, including the name of the medication, dosage, frequency, and prescribing doctor. (Example: Seroquel 300mg, 1 tablet, Twice a day, Dr. Khawaja)

Name of Medication	**Dosage**	**Frequency**	**Doctor**

Past Psychotropic Medications: Please check all the psychiatric meds you have tried before:

Antidepressants: Prozac☐ / Paxil☐/ Zoloft☐/ Celexa☐/ Lexapro☐/ Effexor☐/ Pristiq☐/ Remeron☐/ Wellbutrin☐/ Trintilex☐/ Vybrid☐/ Others:_____

Antianxiety Medications: Buspirone☐/ Xanax☐/ Klonopin☐/ Ativan☐/ Vistaril☐/ Other: _____

Mood Stabilizers: Lithium☐/ Tegretal☐/ Trileptal☐/ Depakote☐/ Neurontin☐/ Gabapentin☐/ Topamax☐/ Other: _____

Antipsychotics: Haldol☐/ Risperdal☐/ Seroquel☐/ Abilify☐/ Clozaril☐/ Geodon☐/ Latuda☐/ Invega☐/ Zyprexa☐/ Vraylar☐, Others:_____

Stimulants: Vyvanse☐/ Adderall☐/ Ritalin☐/ Concerta☐ Others: _____

Hypnotics: Ambien☐/ Lunesta☐/ Benadryl☐/ Trazodone☐/ Vistaril☐/ Melatonin☐/ Belsomra☐/ Ramelteon☐/ Other

Personal Medical History (Please check if you have any of the problems)

Cancer ☐ Anemia ☐

Diabetes Mellitus ☐ Chronic Fatigue☐

Date:

Thyroid Problems ☐
Heart Problems ☐
Blood Pressure Problems ☐
Seizures ☐
Head Injury ☐
Others ☐ Please describe_____
Chronic Pain ☐
Liver Disease ☐
Lung Problems ☐

ALLERGIES: _____

Hospitalizations for medical issues and Surgeries:

Please list any and all previous surgeries: _____

_____

Family History

Has anyone in your family (mother father, siblings, grandparents) had a history of the following:

ADHD ☐ **Drug Addiction** ☐ **Any family member committed suicide** ☐
Alcohol Abuse ☐ **Seizures** ☐ **Schizophrenia** ☐
Anxiety ☐ **Obsessive Compulsive Disorder** ☐. **Violence**☐
Bipolar Disorder ☐. **Phobias** ☐
Depression ☐ **Suicidal attempts** ☐

_____

Review of Systems:

General/Constitutional: Chills☐. Fever☐. Night Sweats☐. Weight gain☐. Weight loss☐
Eyes: Problems with eye sight ☐
Gastrointestinal: Abdominal cramps☐. Bloating☐. Diarrhea☐ Nausea☐. Other_____
Neurology: Burning pain☐. Headache☐. Seizures☐. Tremor☐. Other____
Ear, Nose, Throat: Hearing problems☐. Hoarseness☐. Ringing in Ears☐. Other
Cardiovascular: Chest Pain☐. Leg Swelling☐. Lightheadedness☐. Palpitations☐.
Musculoskeletal: Joint pain☐. Weakness☐
Respiratory: Chest tightness☐. Coughing☐. Shortness of breath☐. Wheezing☐
Genitourinary: Bladder issues☐. Prostate☐
Endocrine: Increased thirst☐. Sweating☐
Hematologic/Lymphatic: Easy bruising☐. Swelling☐
Allergies/Immune: Get infections easily☐
Skin: Rash☐. Ulcers on skin☐
Psychological: Loss of interest in things☐. Depressed Mood☐. Panic attacks☐. Sleep problems☐

Social History/Lifestyle:

Marital Status: Single: ☐, **Married:**☐, **Separated:**☐, **Divorced:**☐
Sexual Orientation: Hetrosexual/Straight:☐, **Homosexual:**☐
What kind of work do you do?_____
Who else lives with you? _____
Any legal problems? ☐
Do you smoke? Yes☐**, No**☐**.** **Do you exercise regularly: Yes**☐**/NO**☐
Have you been in the military: Yes☐**/ No**☐

TREATMENT OPTIONS: We want our patients to be fully engaged in their treatment. We are happy to offer multiple treatment options. We want our patients to be well informed. Please make sure to write down any questions you have for your appointment.

We thank you for completing the questionnaire and for choosing MD TruCare, PA.