SOUTHERN BEHAVIORAL HEALTHCARE, P.C.

QUESTIONNAIRE FOR NEW ADULT PATIENT

PATIENT NAME: **DATE:** **DOB:** **SEX:** M/F

PREF. LANG: English/Spanish/Other **RELIGION:** Christian/Islam/Judaism/No Rel./ Other

RACE: Caucasian/Afri. American/Hispanic/Asian/Other **ETHNICITY:** Cau./AA/Hisp/Asian/Other

PARENT/CAREGIVER/INFORMANT NAME:

Were you referred to us? NO YES If yes, who referred you?

What problems do you have?

Emotional Problems: Circle the one that applies: Depression, Anxiety, Panic Attack, OCD, Mood swings, PTSD, Anger, Social withdrawal, Low Self Esteem, Self-Injury, Psychosis, Sleep Problems, Appetite Problems, Weight Issues, Poor social skills, Suicidal thoughts, Violence, Aggression, Others:

Family/Social Problems: Circle the one that applies: Unemployed, Employment Problems, Housing Problems, Financial Problems, Legal Problems, Others:

School/Day Program Problems: Circle the one that applies: Behavior Issues Academic and Learning Difficulties, Poor Grades, Suspension, Peer problems, Problem with Teachers, Others:

Have you ever made any suicide threat or attempt(s)? NO YES, if yes, explain

Have you ever been abused in the past? NO YES
If yes, What type? When?
Offender? Effect?

Was it reported? NO YES, if yes what was the outcome?

PATIENT NAME: **QUESTIONNAIRE FOR NEW ADULT PATIENT**

Have you ever abused drugs or alcohol? NO YES

If yes, what type? First time? Last use?

Effect : Circle the one that applies: School, Family, Social, Legal, Job, Others:

List Current Medical and Psychiatric Medications:

List Previous Medical and Psychiatric Medications:

Names of Current and Past Psychiatrists:

Names of Current and Past Therapists:

Have you ever been hospitalized? (Medical and Psychiatric) NO YES,

If yes, Name of Hospital Reason(s)

When Outcome

Name of Hospital Reason(s)

When Outcome

Does any member of your family have any Psychiatric problems? NO YES

Circle the one that applies: Depression, Anxiety, Schizophrenia, Bipolar, ADHD, Substance Abuse, Alcohol Abuse, Dementia, OCD, PTSD, Panic Disorder, Autistic Spectrum Disorders, Mental Retardation, Suicide Attempt, Others:

Does any member of your family have any medical problems? NO YES

Circle the one that applies: Asthma Seizures Head Injury Diabetes Hypertension stroke Seasonal Allergies GERD COPD High Cholesterol Migraines Chronic Headaches Cardiac Problems Liver problems Kidney Problems Thyroid Problems Chronic Back Pain Chronic Pain Arthritis Cancer Pancreas Problems Others--

PATIENT NAME: **QUESTIONNAIRE FOR NEW ADULT PATIENT**

FAMILY AND SOCIAL HISTORY: Where were you born?

Are you currently: Single Married If married, how long?

Previous Marriages:

Do you have children: NO YES

If yes, How many? Ages

Mother: Alive Dead

Father: Alive Dead

Siblings: How many? Ages

PAST MEDICAL HISTORY: Do you have any medical problems? NO YES

Circle the one that applies: Asthma Seizures Head Injury Diabetes Hypertension stroke Seasonal Allergies GERD COPD High Cholesterol Migraines Chronic Headaches Cardiac Problems Liver problems Kidney Problems Thyroid Problems Chronic Back Pain Chronic Pain Arthritis Cancer Pancreas Problems Others--

Name of PCP: Tel #

PAST SURGICAL HISTORY: Have you ever had any surgery? NO YES
If yes, what was the problem?

What type of surgery? When?
Where? What was the outcome?

Any complications?

ALLERGY HISTORY: Do you have any drug allergies: NO YES

If yes, name of medications: Type of reaction:

EDUCATIONAL HISTORY: Are you currently in school: NO YES
If yes, what type?

Did you complete: High school GED College Post College

Did you receive any special educational services: NO YES, what type of services?

PATIENT NAME: **QUESTIONNAIRE FOR NEW ADULT PATIENT**

EMPLOYMENT HISTORY: Unemployed Disabled Retired

Employed: Type: How long
Previous Jobs:

SMOKING HISTORY: NO YES, PAST CURRENT How long? How much?

SEXUAL HISTORY: NO YES, Do you practice safe sex: YES NO

LEGAL HISTORY: Have you ever been involved with the Department of Justice:

NO YES, explain?

Have you ever been incarcerated: NO YES, explain?

Have you ever been placed on probation or currently on probation: NO YES, explain?

MILITARY HISTORY: NO YES

What branch of the Military: Army Marine Air Force Navy Reserve

Combat Involvement: NO YES

What type? When? Effect?

Type of Discharge: Honorable Dishonorable

POTENTIAL TREATMENT BARRIERS: Language: YES NO Cognitive: YES NO Cultural: YES NO

Religious: YES NO

SUPPORT SYSTEM: YES NO

What is your treatment goal?

Revised 2/2016