SSMHealth
Dean Medical Group

Department of Psychiatry

# PATIENT HISTORY QUESTIONNAIRE

In order to best assist you, it is important that you complete the following questionnaire prior to your initial consultation. This information will help us better understand you and how we can help. Do the best you can. However, if you do not know how to answer a question or choose not to answer it, you may leave it blank.

Name: _____ Age: _____ Today's Date: _____ / _____ / _____

Date of Birth: _____ / _____ / _____ Sex: Male / Female Race:_____ Religion:_____

Telephone Numbers: Home: _____ Work: _____ Cell:_____

Relationship Status (check all that apply):

| | |
|---|---|
| □ Never married | □ Currently widowed |
| □ Currently married or living with a partner | □ Currently divorced |

Total number of marriages (including current): _____ Length of current relationship: _____

Education (highest grade/degree): _____ Current Occupation: _____

Employer: _____ Length of time at current job: _____

Are you currently involved in any work or health-related disability process? □ Yes □ No

Have you served in the United States Armed Forces? □ Yes □ No If yes, dates:_____

Describe in your own words the major problem(s) or difficulties causing you distress at this time:

_____

_____

_____

What specific event led you to seek mental health services now?

_____

_____

What are your specific needs for treatment at this time? What help are you hoping to receive?

_____

_____

Please list your personal strengths and resources that help you cope with stress (e.g., family support, stable living situation, education, faith, prior response to treatment, etc):

_____

_____

Please list any difficulties with being able to regularly attend scheduled treatment appointments (e.g., work schedule, childcare, transportation, etc):

_____

_____

## MEDICAL STATUS

Primary Care Doctor: _____ Name of Primary Care Clinic:_____

What medications are you taking now? Please list below, including reason for medication and length of time taken (dosage is helpful if known):

_____

_____

_____

_____

Please list any medication allergies: _____

How was your health **during childhood and adolescence**? (Please check)

□ Excellent □ Very Good □ Good □ Fair □ Poor

**In the last 6 months,** would you say your health is: (Please check)

□ Excellent □ Very Good □ Good □ Fair □ Poor

Please list any serious illnesses, accidents, injuries or surgeries in the past and your age at the time. Please list current significant illnesses:

_____

_____

_____

## FAMILY HISTORY

Please list all individuals living in your current household. If you have children who do not live in your household at this time, please list them as well, indicating that they no longer live in this household.

| Name | Relationship | Age | Sex |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Please list all members of your family of origin; that is the family in which you grew up (if this is identical to the above, please omit this section).

| Name | Relationship | Age | Sex | If deceased, give age, cause of death, and your age at the time of relative's death |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Please list in this section individuals who are quite important to you, who may or may not be living in your current household. Please describe their relationship to you (e.g., grandparent, friend, etc):

_____

_____

Please indicate major separations from your parents or guardians and changes in parents or guardians (e.g., went to live with relatives, foster care, etc).

| Age | | Lived With | Reason for change or separation |
|---|---|---|---|
| From | To | | |
| | | | |
| | | | |

Have you been neglected, physically or sexually abused? If yes, by whom and at what age(s) were you?

_____

## SUBSTANCE USE

| How often do you use the following substances? | | | | | |
|---|---|---|---|---|---|
| | Never | Daily | Several times per week | Few times per month | Few times per year |
| **Alcohol** | | | | | |
| **Marijuana** | | | | | |
| **Other drugs** | | | | | |
| **Please list other drugs:** | | | | | |

Have you been concerned that you use any of these substances too much? □ Yes □ No

Has anyone close to you expressed concern about your use? □ Yes □ No

Have you had any problems associated with your use

(e.g., health problems, family conflict, legal problems, OWI)? □ Yes □ No

Have you or others had concerns about your use of prescription drugs? □ Yes □ No

Have you been in treatment for an alcohol/drug issue? □ Yes □ No

| Date(s) of treatment | Location / Name of Clinic |
|---|---|
| | |
| | |

How often do you use caffeine (e.g., coffee, tea, soda, energy drinks, or other caffeinated products)?

□ Never □ Daily □ Several times per week □ Few times per month □ Few times per year

Do you smoke cigarettes? □ Yes □ No □ Ex-smoker □ Trying to quit

Have any of **your relatives** ever had any alcohol or drug problems? (Please list)

| Relationship to you | Type of problem (if known) |
|---|---|
| | |
| | |

## PSYCHIATRIC HISTORY

Have you ever seen a counselor or any healthcare professional for an emotional problem?

□ Yes □ No If yes, please complete the following:

| Dates of Treatment | Diagnosis/reason for treatment | Name of provider and/or institution (clinic, hospital, etc.) | Name of any medication used |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Have you ever been suicidal? □ Yes □ No If yes, was there an attempt? □ Yes □ No

Have any of **your relatives** had any psychiatric problems? (Please list)

| Relationship to you | Type of problem (if known) |
|---|---|
| | |
| | |
| | |

Has any family member ever been suicidal? □ Yes □ No

If yes, was there an attempt? □ Yes □ No

## LEGAL HISTORY

Have you ever been arrested or involved in any legal difficulties? □ Yes □ No

If yes, please explain:

_____

_____

Do you have any concerns about managing your anger? □ Yes □ No If yes, please explain:

_____

_____

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# PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Over the *last 2 weeks*, how often have you been bothered by any of the following problems: (please circle your answer)

| | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|
| 1. Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| 2. Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |
| 3. Trouble falling or staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| 4. Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| 5. Poor appetite or overeating | 0 | 1 | 2 | 3 |
| 6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down | 0 | 1 | 2 | 3 |
| 7. Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | 3 |
| 8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual | 0 | 1 | 2 | 3 |
| 9. Thoughts that you would be better off dead or of hurting yourself in some way | 0 | 1 | 2 | 3 |
| **Add columns:** | | | | |

**Total score*:**

*Score is for healthcare provider interpretation.

| | Not difficult at all | Somewhat difficult | Very difficult |
|---|---|---|---|
| 10. If you circled any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people | | | |

*Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an education grant from Pfizer Inc.*