



Today's Date: _____ Name: _____

Address: _____

DOB: _____ Age: _____ Gender: _____ Race: _____ Marital Status _____

Medical Questionnaire

1. What is the major problem for which you are seeking help at this time?

2. When did this problem begin?

3. Have you ever had this problem before in your life? If so, when:

4. Have you been treated for the above problem or any mental health issues before:

5. Please list all psychiatric medications you have ever taken including anti-depressants, mood stabilizers, anti-psychotics, tranquilizers, sleeping pills and anti-seizure medications: *(Use the back of this sheet if necessary)*

6. Vitamins/ Herbal/Non Prescription Remedies that you have used or are currently using:

7. List all Previous psychiatric hospitalizations: *(Use back of this sheet if necessary)*

Hospital	Location	Dates	Reason	Doctor's Name

8. Alcohol Use per week: Beer (12 oz. cans) Liquor Wine Other: _____

9. Tobacco Use: _____ 10. Caffeinated Drinks per day: _____

11. Illegal Drug Use: _____ () ***I'd like to discuss this issue in person***

Have you ever used following substances?

Alcohol:	caffeine pills:	Cocaine:	crystal meth/amphetamines:	heroin:
Inhalants:	LSD or hallucinogens:	marijuana:	Methadone::	Pain medicines:
PCP:	stimulants(pills):	tranquilizers/sleeping pills:	Ecstasy:	others:

Did you ever stopped using any of the above because of dependence ()N ()Y (Please List)

What was your longest period of abstinence? _____

12. List the dates of any DUI's, traffic accidents or legal problems currently or in the past:

13. List all medical conditions for which you are currently being treated:

14. Medication Allergies:

15. Current Medications:

16. Have you had any surgeries or been hospitalized? (Please explain)

17. Family History of Medical or Psychiatric Illness:

18. Are you currently employed? ()N ()Y What type of work do/did you do?

19. Have you ever had a work related injury or been on Worker's Compensation? If so, for what and when:

20. Are you on Social Security Disability? If so when did it begin and for what reason?

21. Highest Level of Education:

22. Were you ever in the military? If so, when, what division and type of discharge?

23. Have you ever been a victim of trauma? () N () Y

Physically Sexually (including rape or attempted rape) Verbally Emotionally

24. Have you ever been arrested or convicted? N Y

If yes, was it..... DUI Drug related Domestic violence Other

25. Have you ever attended: (If Yes) -

AA Current Past NA Current Past

26. Have you ever been treated for substance misuse? (N Y (Please describe when, where and for how long)

NAME: _____ SIGNATURE: _____ Dated: _____