# McLean Behavioral Health
# Patient Questionnaire

Date: _____

Name: _____

Age: _____ Date of Birth _____

Address: _____

What is the chief complaint:

Do you feel depressed: ☐Yes ☐No How much are you sleeping :_____ hours

How is your appetite: ☐Good ☐Poor How is your energy: ☐Good ☐Poor

Do you have crying spells: ☐Yes ☐No Do you worry a lot? ☐Yes ☐No

Do you get anxiety attacks (when you have heart palpitation, chest tightness, shortness of breath, dizziness): ☐Yes ☐No If yes, how often: _____ per week

Are you obsessed with certain thoughts (Like something bad will happen ): ☐Yes ☐No

Do you do certain rituals, or repetitive actions to get rid of the obsessive thoughts: ☐Yes ☐No

Did you ever experience abuse: ☐Yes ☐No

If yes, was it ☐Emotional ☐Verbal ☐Physical ☐Sexual

Do you get nightmares or flashbacks of the abuse? ☐Yes ☐No

Do you experience hallucinations (see things or hear things which aren't there) ☐Yes ☐No

Are you allergic to any medications: ☐Yes ☐No

| If yes: Name | Reaction |
| --- | --- |
| | |
| | |

Have you been hospitalized for psychiatric reasons: ☐Yes ☐No

if yes, How many times: _____

| Name of hospital | Year | Reason |
|---|---|---|
| | | |
| | | |

Have you seen a Psychiatrist in the past: ☐Yes ☐No

| Name | Duration | Reason |
|---|---|---|
| | | |
| | | |

Have you seen a psychologist in the past: ☐Yes ☐No

| Name | Duration | Reason |
|---|---|---|
| | | |
| | | |

Have you ever attempted suicide: ☐Yes ☐No

Are you taking any psychiatric medications: ☐Yes ☐No

If yes, please give details:

| Name | Dose | Frequency | Duration | Reason |
|---|---|---|---|---|
| | | | | |
| | | | | |

Review of Systems:

| | | | |
|---|---|---|---|
| Headaches: | ☐Yes ☐No | Chest pain: | ☐Yes ☐No |
| Shortness of breath: | ☐Yes ☐No | Pain: | ☐Yes ☐No |
| Acid reflux: | ☐Yes ☐No | Asthma: | ☐Yes ☐No |
| Hypertension: | ☐Yes ☐No | Heart Disease: | ☐Yes ☐No |
| Hypothyroidism: | ☐Yes ☐No | Diabetes: | ☐Yes ☐No |

Others:

Surgeries: ☐Yes ☐No

Any family member who has any diagnosed psychiatric condition: ☐Yes ☐No

If yes: Relationship Diagnosis

Marital Status:☐Married/Domestic Partner ☐Single ☐Widowed ☐Divorced ☐Separated

With whom do you now live:_____

What is your highest level of education: _____

Present Job / employment: _____

Do you have any current legal issues pending : ☐Yes ☐No

If yes, describe : _____

Past convictions: ☐Yes ☐No

If yes, describe: _____

How much do you smoke: ☐None ☐Regularly, _____/per day

Have you quit smoking? ☐No ☐Yes If yes, when? _____