Plymouth Psych Group

PATIENT QUESTIONNAIRE AND HISTORY FORM

Name: (Last, First, M.I.)	**Date of Birth:**

Part A: General Information

Education

Level of Education	Name of Institution	Dates	Diploma/Degree Earned
High School or GED			
College or Tech. School			
Graduate School			
Other: _____			

Work History *(most recent 3 jobs)*

Start/End Dates	Employer	Job Title	Reason for Leaving

Living Arrangements & Lifestyle

I am: ____Married ____Never Married ____Separated ____Divorced ____Living Together

List all individuals living in the home:

Name	Relationship	Age

Custody and Visitation Arrangements, if applicable *(include any litigation/legal issues):*

_____

Diet and Exercise Habits: _____

_____

Sleep Routine: _____

Spiritual, Religious and/or Cultural Preferences *(optional)*: _____

_____

Hobbies and Leisure Activities: _____

_____

Part B: Patients/Clients Under the Age of 18 *(if over 18, skip to Part C)*

Academic History

Current Grade Level	Name and Location of School

Please mark all that apply:

_____ Separation Issues		Describe:
_____ Diagnosed Learning Disabilities		Describe:
_____ Trouble with Teachers		Describe:
_____ Trouble with Peers		Describe:
_____ Trouble with Absences		Describe:
_____ Trouble with Grades		Describe:
_____ Frequently Disruptive in Class		Describe:

Hobbies and Extracurricular Activities: _____

_____

Developmental History

☐ **Child Was Adopted** *(if yes, skip first two questions below)*

Describe the pregnancy *(was it planned? any complications? etc.)*: _____

_____

Describe the labor/delivery *(born on due date? any complications? etc.)*: _____

_____

List any congenital issues: _____

_____

Has your child met all of their developmental milestones? Include any delays, if applicable:

_____

Describe your child's temperament: _____

_____

Part C: Health Information *(All Patients Continue Here)*

List any current medications, supplements, or alternative medicine:

Name	Dosage	Frequency	Response

Preferred Pharmacy:

Name	Address	City, State, Zip

List any medical hospitalizations and surgeries:

Date (start/end)	Issue	Response

Indicate any history of the following:

Ailment	How Long?	Describe
_____ Allergies to medication		
_____ Allergies to environment or food		
_____ Chronic illness		
_____ Current medical condition(s)		
_____ Head injury, concussion, or seizure		

Substance use information

Substance	Frequency	Current	Past
_____ Caffeine			
_____ Steroids			
_____ Nicotine			
_____ Alcohol			
_____ Marijuana			
Other: _____			

Are there substance use issues impacting your family? _____ Yes _____ No

If yes, with whom? _____

History of abuse or trauma *(witnessed or experienced a life-threatening event)*

Type	Description	Frequency
Physical		
Sexual		
Emotional		
Verbal		
Other Trauma		

Previous mental health treatments *(include hospitalizations, outpatient programs, psychological testing, etc.)*

Type of Treatment	Dates	Outcome

What brings you here today?

_____ Medication Management/Review	_____ Psychological Evaluation
_____ Individual Therapy	_____ Psychological Testing
_____ Couples Therapy	_____ Family Therapy

Please tell us what you would like to address during this initial appointment:

What are your overall goals for receiving care at our clinic? List them here:

1.) _____

2.) _____

3.) _____

Please mark any current concerns regarding *MOOD* and indicate duration of symptoms:

Mood	How Long?		Mood	How Long?
____Angry/Aggressive			____ Feeling inadequate	
____ Anxious, worried			____ Jealousy	
____Confused			____ Lonely	
____Depressed			____ Paranoid	
____Fear			____Suicidal thoughts	

Please mark any current concerns regarding BEHAVIOR and indicate duration of symptoms:

Behavior	How Long?	Behavior	How Long?
____ Abuse to animals		____ Lacking motivation	
____ Acts too young for age		____ Lying	
____ Alcohol abuse		____ Need for constant reassurance	
____ Audial or visual hallucinations		____ Nervous mannerisms	
____Clingy, avoids being alone		____ Obsessive	
____ Crying excessively		____ Panic attacks	
____ Destructive		____ Perfectionist	
____ Difficulty sitting still		____ Pessimistic outlook	
____ Drug abuse		____ Runaway	
____ Easily distracted		____ Self-Conscious	
____ Eating habits		____ Self-harm	
____ Excessively dependent		____ Sexual promiscuity	
____ Fatigue		____ Shoplifting/Stealing	
____ Fire setting		____ Sleeping difficulty	
____ Impulsive		____ Tense	
____ Inappropriate expression of feelings		____ Trouble focusing	
____ Inappropriate sexual behavior		____Violation of parental or legal limits	
____ Irritability		____ Withdrawn	

How are the above MOOD and BEHAVIOR issues impacting your daily functioning?

Part D: Family Health Information

Describe any notable MEDICAL history in your family *(diabetes, thyroid, etc.)***:**

Relationship	Description of Issue
Mother	
Father	
Sibling(s)	
Extended Family	

Describe any notable PSYCHIATRIC/MENTAL HEALTH history in your family:

Relationship	Description of Issue
Mother	
Father	
Sibling(s)	
Extended Family	