Superior Psychiatric Services
A Professional Medical Corporation
1400 Quail Street, Ste. 155, Newport Beach, CA 92660

New Patient Questionnaire

In order for us to be able to evaluate you we need to first gather some information about you. Please print this form, complete it and bring it with you to your first session. We realize that this is a lot of information and that much of it may be sensitive. Also, you may not remember or have access to all of it. Do the best you can. Thank you!

Alexis Meshi, M.D.
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Patient Information:

Patient's Name_____
Social Security Number (SS#):_____ - _____ - _____
Gender: Please Indicate: Female[ ] Male[ ]
Date of Birth: _____ Age: _____
Marital Status: Single[ ] Married[ ] Separated[ ] Divorced[ ] Widowed[ ]
Home Address _____ City_____
State ____ Zip_____
Home Phone: _____ - _____ - _____
E-mail Address:_____
Phone:_____ - _____ - _____Mobile: _____ - _____ - _____
Driver's License Number: _____State:_____
Religion: _____ Race: _____ # of Children:_____
Occupation: _____
Student/Employer (School, if student): _____
Work/School Phone: _____ - _____ - _____
Employer/School Address: _____ City:_____
State:_____ Zip: _____

Spouse's Information

Spouse's Name (if applicable): _____
SS#_____ - _____ - _____
Date of Birth: _____Age: _____
Spouse's Occupation/Employer: _____

Responsible Party (skip if Patient is also Responsible Party):

Responsible Party's Name:_____
SS#_____ - _____ - _____
Date of Birth: _____Age: _____
Home Address:_____
Home Phone: _____ - _____ - _____Mobile: _____ - _____ - _____
Occupation:_____
Employer: _____
Work Phone: _____ -_____ - _____
E-mail Address:_____
Employer Address: _____
Driver's License Number:_____ State:_____
Marital Status: Single[ ] Married[ ] Separated[ ] Divorced[ ] Widowed[ ]

Referral Source (if any):

Referral Source (who referred you to us): _____
Phone Number: _____ - _____ - _____ FAX_____ - _____ - _____
Do we have your permission to release information to the referring professional when it is appropriate?: Yes [ ] No [ ]

Questionnaire: to be answered by prospective patient

What is the main purpose of this consultation (Please provide a brief summary of the main problems)?:

_____
_____
_____
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_____

Why did you seek the evaluation at this time? What are your goals in being here?

Prior/present Psychiatric Medications - this information is required by Dr. Meshi to perform a thorough evaluation:

1. The name of the medication
2. The milligram (mg.) dose
3. The amount of tablets or mg you took/take in one day
4. The approximate dates taken – preferably in sequential order
5. Whether the medicine worked well, worked partially, or didn't work at all.
6. Did you take any medications in combination with other medications?
7. Any side effects or adverse effects from the medication

If you need more room, please attach another sheet.

Prior attempts to correct problems / prior Psychiatric history (Please include contact with other Healthcare professionals, medications, types of treatment, etc.)_____
_____
_____
_____
_____
_____

Medical history - current medical problems and medication:
_____
_____
_____
_____
_____
_____
_____

Current supplements, vitamins or herbs:
_____
_____
_____
_____
_____
_____

Past medical problems/medications:
_____
_____
_____
_____
_____
_____

Other doctors/clinics seen regularly:
_____
_____

Any history of head trauma, concussion or significant accidents? Describe:
_____
_____
_____
_____
_____

Ever had any seizures or seizure like activity?
_____

Prior hospitalizations (place, cause, date, outcome):

_____
_____

Prior abnormal lab tests, X-rays, EEG, etc:

_____
_____

Allergies/drug intolerances (describe):

_____
_____

Present Height ___Ft ____In / Present Weight _____Lbs.
For females, date started last menstrual period: _____

Current life stresses (include anything that is currently stressful for you, for example relationships, job, school, finances, children)

_____
_____
_____
_____
_____
_____
_____
_____

Prenatal and Birth Events:

Your parents' attitudes toward their pregnancy with you:

_____
_____

Pregnancy complications (bleeding, excess vomiting, medication, infections, x-rays, smoking, alcohol/drug use, Etc

_____
_____
_____

Any birth problems, trauma, forceps or complications?

_____
_____

Sleep Behavior:

Any problems falling asleep?

_____
_____

Any problems staying asleep?

_____
_____

Any problems waking up?

_____
_____

On average, how many hours do you sleep per night?

_____

Any history of sleepwalking, recurrent dreams, sleep apnea, heavy snoring, or sleep bruxism (grinding your teeth)?

_____
_____
_____
_____
_____
_____

Diet/Exercise History:

Would you consider your diet mostly healthy or unhealthy?

_____

Any food allergies/sensitivities?

_____
_____

Caffeine consumption per day (i.e. coffee, soda, tea, chocolate):

_____

How many days a week do you eat fruits?_____ vegetables?_____ breakfast?_____

Describe your current bowel function:

_____

Describe your current exercise regimen:

_____

School History:

Last grade completed:_____
Last school attended:_____
Average grades received:_____
Specific learning disabilities: _____

Learning strengths:

_____
_____

Any behavior problems in school?

_____

What have teachers said about you?

_____
_____

Employment History: (summarize jobs you've had, list most favorite and least favorite):

_____
_____
_____
_____
_____
_____

Any work-related problems?

_____
_____

What would your employers or supervisors say about you?

_____
_____

Military history?

_____
_____

Ever had any legal problems? (including traffic violations)

_____
_____
_____
_____
_____

Alcohol and Drug History:

(Please list age started and types of substances used through the years and any current usage. Also, describe how each of these substances made you feel and what benefit did you get from them).These substances may include alcohol (hard liquor, beer, wine), marijuana or hash, prescription tranquilizers or sleeping pills, inhalants (glue, gasoline, cleaning fluids, etc.), cocaine or crack, amphetamines or crank or ice, steroids, opiates (heroin, codeine, morphine or other pain killers), barbiturates, hallucinating drugs (LSD, mescaline, mushrooms), and PCP.

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_____

Do you or have you ever experienced withdrawal symptoms from alcohol or drugs?_____

Has anyone told you they thought you had a problem with drugs or alcohol?
_____

Have you ever felt guilty about your drug or alcohol use?

_____
_____

Have you ever felt annoyed when someone talked to you about your drug or alcohol use?

_____
_____

Have you ever used drugs or alcohol first thing in the morning?

_____
_____

Nicotine use per day, past and present, (nicotine is in cigarettes, cigars, tobacco chew):

_____

Sexual history: (answer only as much as you feel comfortable)

Age at the time of first sexual experience: _____
Number of sexual partners: _____
Any history of sexually transmitted disease? _____
History of abortion? _____
History of sexual abuse, molestation or rape?
_____
_____
Current sexual problems?
_____
_____
Any history of being physically abused?:
_____
_____
_____
_____
_____
_____

Family History:

Family Structure (who lives in your current household, please give relationship to each):
_____
_____
_____
_____
_____
_____

Current Marital or Relationship Satisfaction:
_____
_____
_____
_____
_____

Significant Developmental Events (include marriages, separations, divorces, deaths, traumatic events, losses, abuse, etc.)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

History of Past Marriages:

_____
_____

Natural Mother's History:

Age_____ Occupation _____
School: highest grade completed _____ High school graduate?: Yes[ ] No[ ]
College: Graduated?: _____
Learning problems _____
Behavior problems _____
Marriages _____
Medical Problems

_____
_____
_____
_____
_____

Mother's childhood atmosphere (family position, abuse, illnesses, etc):

_____
_____
_____
_____
_____

Has mother ever sought psychiatric treatment? Yes ___ No ___ If yes, for what purpose?

_____
_____
_____
_____
_____

Mother's alcohol/drug use history:

_____
_____
_____
_____
_____

Have any of your mother's blood relatives ever had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalizations? (Specify):

_____
_____
_____
_____

Natural Father's History:

Age_____ Occupation _____
School: highest grade completed _____ High school graduate?: Yes[ ] No[ ]
College: Graduated?: _____
Learning problems _____
Behavior problems _____
Marriages _____
Medical Problems:

_____
_____
_____
_____
_____
_____

Father's childhood atmosphere (family position, abuse, illnesses, etc):

_____
_____
_____
_____
_____

Has father ever sought psychiatric treatment? Yes[ ] No[ ] If yes, for what purpose?

_____
_____
_____

Father's alcohol/drug use history

Have any of your father's blood relatives ever had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalizations? (specify):

Patient's siblings (names, ages, problems, strengths, relationship to patient):

Children (names, ages, problems, strengths):

Cultural/Ethnic Background:

Describe your relationships with your friends:

_____
_____
_____
_____
_____

Describe yourself:

_____
_____
_____
_____
_____

Describe your strengths:

_____
_____