BOSTON MINDCARE

# CONFIDENTIAL PATIENT QUESTIONNAIRE STAFF SENT TO NP

NAME _____ DATE OF BIRTH: _____

NAME YOU PREFER TO BE CALLED _____

PHONE # FOR PRIVATE CALLS _____

ADDRESS _____

_____

EMAIL ADDRESS _____

EMERGENCY CONTACT _____

EMERGENCY CONTACT PHONE _____

WHERE DID YOU HEAR ABOUT US? _____

REFERRING CLINICIAN NAME _____

REFERRING CLINICIAN PHONE # _____

PSYCHIATRIST IF DIFFERENT FROM ABOVE: _____

PSYCHIATRIST PHONE # _____

THERAPIST IF DIFFERENT FROM ABOVE: _____

THERAPIST PHONE # _____

PRIMARY CARE PHYSICIAN NAME _____

PRIMARY CARE PHYSICIAN PHONE # _____

HEIGHT: _____ WEIGHT: _____ STAFF: PAID ☐ YES ☐ NO

BOSTON MINDCARE

# PSYCHIATRIC HISTORY

PRINCIPAL PSYCHIATRIC DIAGNOSIS:

- ☐ MAJOR DEPRESSION
- ☐ BIPOLAR DISORDER
- ☐ PTSD
- ☐ OTHER _____

NUMBER OF YEARS WITH MENTAL ILLNESS: _____

ANY HISTORY OF VISUAL OR AUDITORY HALLUCINATIONS? ☐ YES ☐ NO

ADDITIONAL DIAGNOSES:

_____

_____

_____

_____

CURRENT SYMPTOMS:

_____

_____

_____

PAST SYMPTOMS / DIAGNOSES

- ☐ MANIA
- ☐ PSYCHOSIS
- ☐ SCHIZOAFFECTIVE DISORDER
- ☐ SCHIZOPHRENIA
- ☐ OTHER _____

| | | | |
|---|---|---|---|
| SUICIDAL BEHAVIOR / ATTEMPTS? | | ☐ YES | ☐ NO |
| HISTORY OF PHYSICAL ABUSE? | | ☐ YES | ☐ NO |
| HISTORY OF SEXUAL ABUSE? | | ☐ YES | ☐ NO |
| RECENT LOSSES? | | ☐ YES | ☐ NO |
| PLEASE EXPLAIN: _____ | | | |
| ACCESS TO FIREARMS? | | ☐ YES | ☐ NO |
| DOMESTIC VIOLENCE? | ☐ CURRENT | ☐ PAST | ☐ NO |

BOSTON MINDCARE

# SOCIAL HISTORY

EDUCATION:

- ☐ HIGH SCHOOL
- ☐ TRADE SCHOOL
- ☐ COLLEGE
- ☐ POST-GRADUATE
- ☐ OTHER TRAINING _____

CURRENT LIVING SITUATION:

- ☐ ALONE
- ☐ WITH ROOMMATE(S)/FRIEND(S)
- ☐ WITH PARTNER
- ☐ WITH PARENTS

SOCIAL SUPPORTS:

- ☐ PARTNER
- ☐ PARENTS
- ☐ CLOSE FRIENDS
- ☐ ADULT CHILDREN
- ☐ COMMUNITY (PLACE OF WORSHIP, NEIGHBORHOOD, ACTIVITIES)
- ☐ OTHER _____

FAMILY PSYCHIATRIC HISTORY – HAS ANYONE IN YOUR FAMILY HAD

- ☐ DEPRESSION
- ☐ SUICIDAL BEHAVIOR
- ☐ SUBSTANCE ABUSE / ALCOHOLISM
- ☐ DEMENTIA / ALZHEIMER
- ☐ OTHER PSYCHIATRIC DISORDERS

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| CURRENT PSYCHIATRIC MEDICATIONS | DOSE | FREQUENCY |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

MEDICATIONS/TREATMENTS/PROCEDURES TRIED BUT DISCONTINUED & DURATION

| | | | |
|---|---|---|---|
| COCAINE | ☐ YES | ☐ NO | |
| LAMICTAL (LAMOTRIGINE) | ☐ YES | ☐ NO | |
| BENZODIAZEPINES (ATIVAN, KLONOPIN, XANAX) | ☐ YES | ☐ NO | |
| MAOI'S (SUCH AS NARDIL, PARNATE, EMSAM) | ☐ YES | ☐ NO | |
| FYCOMPA (PERAMPANEL) | ☐ YES | ☐ NO | |
| TOPOMAX (TOPIRAMATE) | ☐ YES | ☐ NO | |
| GABITRIL (TIAGABINE) | ☐ YES | ☐ NO | |
| SABRIL (VIGABATRIN) | ☐ YES | ☐ NO | |
| NEURONTIN (GAPAPENTIN) | ☐ YES | ☐ NO | |
| LYRICA (PREGABALIN) | ☐ YES | ☐ NO | |
| MIRENA IUD OR ESTROGEN THERAPY | ☐ YES | ☐ NO | |

HAVE YOU HAD...

- ☐ ECT LOCATION & DATE(S): _____
- ☐ TMS LOCATION & DATE(S): _____
- ☐ OTHER TREATMENTS _____

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OUTPATIENT THERAPY ☐ NONE

| CLINICIAN/PROGRAM | LOCATION | DATE |
|---|---|---|
| | | |
| | | |
| | | |

EMERGENCY ROOM VISITS FOR PSYCHIATRIC REASONS ☐ NONE

| HOSPITAL | REASON | DATE |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

PSYCHIATRIC HOSPITALIZATIONS ☐ NONE

| HOSPITAL | REASON | DATE |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

☐ RECENT E.R. VISITS FOR NON-PSYCHIATRIC REASONS? (EXPLAIN) _____

_____

BOSTON MINDCARE

CURRENT MEDICATIONS (NON-PSYCHIATRIC) DOSE FREQUENCY

_____

_____

_____

_____

_____

MEDICATIONS THAT CAUSE ALLERGIES/REACTIONS: REACTION:

_____

_____

_____

_____

| SUBSTANCE USE: | QTY/FREQUENCY: | HOW MANY YRS: | LAST USE: |
|---|---|---|---|
| TOBACCO | | | |
| ALCOHOL | | | |
| MARIJUANA | | | |
| COCAINE | | | |
| HEROIN | | | |
| OTHER | | | |

☐ YES ☐ NO FAMILY HISTORY OF SUBSTANCE ABUSE / ALCOHOLISM?

ANESTHESIA EXPERIENCES: _____

_____

_____

☐ FAMILY HISTORY OF A SERIOUS ADVERSE REACTION TO ANESTHETICS (EXPLAIN)

_____

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MEDICAL PROBLEMS (CHECK ANY THAT APPLY):

☐ HIGH BLOOD PRESSURE

IF ON MEDS: IS YOUR BLOOD PRESSURE UNDER CONTROL? ☐ YES ☐ NO

WHAT IS YOUR USUAL BLOOD PRESSURE OFF/ON MEDS (IF KNOWN)? _____

☐ RECENT CHEST PAIN ☐ RECURRING CHEST PAIN/TIGHTNESS ☐ CHF

☐ HEART ATTACK ☐ PALPITATIONS ☐ HEART RHYTHM ISSUES/ IRREGULAR HEARTBEAT

☐ FAINTING ☐ SWELLING ☐ DIFFICULTY EXERCISING

☐ HEART MURMUR OR VALVE ISSUE ☐ COPD/EMPHYSEMA/BRONCHITIS

☐ ASTHMA ☐ USE OF HOME OXYGEN ☐ PULMO. HYPERTENSION

☐ OTHER LUNG ISSUES ☐ SLEEP APNEA ☐ DIABETES

☐ THYROID PROBS. ☐ SEIZURES ☐ STROKE / TIA

☐ HEAD TRAUMA ☐ MIGRAINE ☐ OTHER HEADACHE

☐ COGNITIVE PROBLEMS ☐ VISIONS/VOICES ☐ DEMENTIA

☐ DIZZINESS ☐ NUMBNESS/TINGLING ☐ UNSTEADY GAIT

☐ VISION CHANGES/PROB ☐ OTHER NEUROLOGIC PROBLEMS ☐ HEARTBURN/GERD

☐ ABDOMINAL PAIN ☐ NAUSEA/VOMITING ☐ DIARRHEA/CONSTIP.

☐ IBS/OTHER GI PROB. ☐ CHRONIC PHYSICAL PAIN ☐ ABNORMAL BLEED

☐ ABNORMAL BLOOD CLOT ☐ ANEMIA ☐ KIDNEY PROBLEMS

☐ GYNECOLOGIC ISSUES ☐ MUSCLE PROBLEMS ☐ SKIN PROBLEMS

☐ BONE/JOINT PROBLEMS ☐ INFECTION / IMMUNITY ISSUES

☐ PREGNANCY OR POSSIBILITY OF PREGNANCY LAST MENSTRUAL PERIOD: _____

PLEASE PROVIDE ANY EXPLANATIONS OF THE ABOVE OR OTHER CONDITIONS THAT YOU FEEL WOULD BE HELPFUL OR IMPORTANT FOR A TREATING PHYSICIAN TO KNOW:

I UNDERSTAND THERE IS A $50 BOOKING FEE CANCELLATION FOR CONSULTATIONS AND $300 CANCELLATION FEE FOR APPOINTMENT CANCELLATIONS MADE IN LESS THAN A 24 HOUR TIME PERIOD.

I CERTIFY THAT I PERSONALLY HAVE COMPLETED THIS MEDICAL AND PSYCHIATRIC HISTORY TO THE BEST OF MY KNOWLEDGE. I AGREE TO SEEK IMMEDIATE HELP FROM A SUICIDE HOTLINE, LICENSED MENTAL HEALTH PROVIDER, AND/OR HOSPITAL EMERGENCY DEPARTMENT IN THE EVENT THAT MY SYMPTOMS WORSEN OR I EXPERIENCE AN INCREASE IN SUICIDAL THOUGHTS, FEELINGS, OR URGES.

REVIEWED BY:

PATIENT SIGNATURE, DATE, & TIME