Washington Behavioral Medicine Associates, LLC
5480 Wisconsin Ave., Suite 223
Chevy Chase, Maryland 20815
Telephone: (301)576-6044
Fax: (301)576-1645

History Questionnaire for Adults

Instructions:

The purpose of this questionnaire is to obtain a comprehensive picture of your circumstances and difficulties. This is a general questionnaire that covers many aspects of psychiatry some may not apply to you please state that those are not applicable (N/A). If you do not desire to answer any questions merely write "do not care to answer," but please respond to ALL questions. Answering these questions as fully and as accurately as possible will assist in completing your evaluation. You are requested to answer these routine questions in your own time instead of using your actual consulting time, especially because you may not remember some of the answers right away. Please return the form to me, in the enclosed envelope, BEFORE your consultation.

It is understandable that you may be concerned about what happens to this information, because much of this is highly personal. Case records are strictly CONFIDENTIAL. No outsider, not even your closest relative or family doctor, is permitted to see this record without your written permission.

If you have had a previous evaluation or treatment, or have been hospitalized, please contact all previous physicians, therapists or hospitals immediately, and send each of them a signed request form asking them to send a copy of your case history to me, before your consultation. (Consent for release of Patient Information forms are included at the back of this packet for this purpose.) This is very IMPORTANT. Doctors and hospitals are often slow to answer such requests. You should call the physician/institution in addition to sending them the enclosed request form.

A. General Information

Date:			
Last Name:			
First Name:		Middle Initial:	
Address:			
Home Tel.:	Work Tel.:	Cell:	
Date of Birth:	Age:	Height:	Weight:
Place of Birth:	Occupation:		
With whom are you living? (list people):			
Do you live in a house, condo, hotel room, apartment, etc.?			
Marital status: single, married, separated, divorced, widowed, living with significant other			
Referred by:		Telephone:	
Address:			

Please describe in your own words what brought you in for a consultation:

When was the last time you felt well both physically and emotionally for a sustained period?
How is most of your free time occupied?
Present interests, hobbies, activities:

B. Psychiatric History

a. Please list and give complete information about whom you have consulted previously

Name and Profession	Type of treatment (medication, psychotherapy, both)	Dates of treatment (initial consultation, frequency, termination, ongoing)	Reason for termination (if applicable)

b. Please list and give complete information about psychiatric hospitalizations if any:

Hospital and doctor's name	Dates and/or length of hospitalization	Reason for hospitalization

c. Please list and give complete information about previously and currently used psychiatric medications including over-the-counter and herbal preparations. Start with medications you are currently using. (Please see list on last page for help with names, continue on the back of this page if more space is needed). If unsure or unclear on what medication was used additional information can be obtained from your pharmacy records.

Medication	Dates taken (From and to/current)	Highest dosage taken	Results (positive or negative)	Side effects	Reason for discontinuation

d. Where you ever treated with electroconvulsive therapy (ECT), transcraneal magnetic stimulation (TMS) deep brain stimulation (DBS) and/or vagal nerve stimulation (VNS)

☐ Yes ☐ No

d. Have you ever had any ideas of suicide? ☐ Yes ☐ No

Have you ever attempted suicide? ☐ Yes ☐ No

If so, how many times? _____

Please explain on the back of this page what led you to consider suicide, what was your attempt and if you were hospitalized after the attempt. Please describe each attempt.

e. Have you ever been violent? ☐ Yes ☐ No

Please explain on the back of this page what led you to violence, what you did and was the police involved. Please describe each episode.

f. Have you ever been arrested? ☐ Yes ☐ No

Please explain on the back of this page what led your arrest. Please describe each episode.

C. Social History

a. Childhood

Please check any of the following that applied to your childhood (give details on the back):

☐ Hyperactivity
☐ Conduct problems
☐ Sleep walking
☐ Learning difficulties
☐ Night terrors
☐ Stammering

☐ Fears/worries
☐ Unhappy childhood
☐ Abuse physical/emotional/sexual
☐ Happy childhood

Games and interests during childhood:
Interests and hobbies during adolescence
Any athletic accomplishments?

b. Educational History

Age of beginning school:	Age of finishing school:
Last grade in school:	
Relationship with schoolmates:	
Scholastic abilities:	
Scholastic disabilities:	
Were you ever bullied or given a nickname? (please give details in the back)	
Do you make friends easily?	Do you keep them?
Did you experience fear of leaving your mother to go to school or camp? (Please give details in the back).	
Did you experience nausea and/or vomiting before going to school?	
Did you attend college?	
What did you major/minor in? (if applicable)	
Did you attend graduate school?	
What is your degree? (if applicable)	

c. Occupational history

1. Age of starting work: _____

2. Jobs held (in chronological order) and reason for change:

3. Does your present job satisfy you? If not in what ways are you dissatisfied?

What were the maximum earnings you made? _____

What are you earning now? _____

How much does it cost you to live? _____

d. What is your sexual orientation?
Heterosexual, gay, lesbian, bisexual, transexual

e. Do you practice safe sex? ☐ Yes ☐ No ☐ Not applicable

f. Personal relationship history

Are you in a marital/long-term relationship ☐ Yes ☐ No
How long did you know your partner before engagement?
How long were you engaged?
Partner's age:
Partner's occupation:
Partner's personality (in your own words):
In what areas is there compatibility?
In what areas is there incompatibility?
Please give details of any previous marriages or long-term relationships and how they were terminated

Year relationship began	Year relationship ended	Reason (divorce, separation, death of partner)

e. Children

Do you have any children? ☐ No ☐ Yes – please list in chronological order				
Name	Age	Sex	Describe any problems they may have	Do they live with you?
1.				☐Yes ☐No
2.				☐Yes ☐No
3.				☐Yes ☐No

f. Family relationships

1. Father

Name:	Age:
Occupation:	Health:
If deceased, cause of death:	
Your age at time of death:	

2. Mother

Name:	Age:
Occupation:	Health:
If deceased, cause of death:	
Your age at time of death:	

3. Siblings: (If any are deceased please give your age at the time of death and cause of death).

Name	Age	Gender	Marital Status	Occupation / observations

Relationship with siblings:

Past:
Present:

Please give a description of your father's personality and his attitude towards you

Past:
Present:

Please give a description of your mother's personality and her attitude towards you

Past:
Present:

Were you ever separated from one or both parents during your childhood or adolescence (other than vacations) for more than a month? ☐No ☐Yes – please describe fully and give your age on the back of this page.

If you have a step-parent give your age when parent remarried: _____
If you were not brought up entirely by parents, who did bring you up, and between what years?
In what ways were you punished by parents as a child?
Give an impression of your home atmosphere:
Were you able to confide in your parents?
Was religion important growing up? If so which religion did you follow?
Who are the most important people in your life?

g. Substance use

Please describe use of alcohol, caffeine, tobacco and/or drugs (i.e. : marijuana, cocaine, heroin, ecstasy, PCP, GHB, amphetamines, etc.)

Substance	Age at first use	Last use	Ever in treatment for this substance	Currently using?
			☐Yes ☐No	☐Yes ☐No
			☐Yes ☐No	☐Yes ☐No
			☐Yes ☐No	☐Yes ☐No
			☐Yes ☐No	☐Yes ☐No

Did you ever go through detoxification and/or rehabilitation for any of these substances?
☐Yes ☐No

D. Family History

a. Medical family history

Has any member of your family (parents, siblings, grandparents, children, significant other, etc.) ever had any medical problems (for example diabetes, high blood pressure, epilepsy, seizures, high cholesterol, stroke, heart problems, etc.)

List family member	Describe problem	Describe treatment of hospitalization for this problem

b. Psychiatric family history

Has any member of your family (parents, siblings, grandparents, children, significant other, etc.) ever had any psychiatric problems whether diagnosed or suspected (for example anxiety, phobias, depression, manic depressive illness, schizophrenia, etc.). Please also include those who may have seemed odd or had school/learning difficulties.

List family member	Describe problem	Describe treatment of hospitalization for this problem

c. Substance abuse family history

Has any member of your family (parents, siblings, grandparents, children, significant other, etc.) ever had any problems with drugs or alcohol?

List family member	Describe problem	Describe treatment of hospitalization for this problem

E. Medical History

a. Allergies

Do you have any allergies to medication? ☐ No ☐ Yes – please describe	
Medication name	Reaction
Do you have any other allergies to food/insects/etc.? ☐ No ☐ Yes – please describe	
Allergy type	Reaction

b. Medical illnesses or health problems

Describe illness or health problem	Your age at time
List any surgeries/operations you had	Your age at time

List any accidents you had	Your age at time

c. Menstrual/pregnancy history ☐ Not applicable

Age at first period:
Are periods regular? ☐ Yes ☐ No
Duration
Are they heavy? ☐ Yes ☐ No
Do periods affect your moods? ☐ Yes ☐ No
Do you experience (check all that apply) ☐ Irritability ☐ Anxiety ☐ Depression
Date of last period

2. Please list all pregnancies you have had in chronological order and give complete information requested below. If more space is needed, continue on the back of this page.

Year	Number of months pregnancy lasted	Describe illnesses or complications during pregnancy or delivery	Outcome
1.			☐ miscarriage ☐ elective abortion ☐ living child
2.			☐ miscarriage ☐ elective abortion ☐ living child
3.			☐ miscarriage ☐ elective abortion ☐ living child
4.			☐ miscarriage ☐ elective abortion ☐ living child
5.			☐ miscarriage ☐ elective abortion ☐ living child

3. Non-psychiatric medications including oral contraceptives

Please include all medications that you can recall taken in the past and currently:

Medication name and dosage	Dates taken (From and to/ currently taking)	Reason that medication was prescribed	Results (positive or negative)	Reason for discontinuation

Addendum

List of psychotropic medications

Adapin (Doxepin)
Alprazolam
Amantadine
Amitriptyline
Amoxapine
Anafranil (Clomipramine)
Antabuse (Disulfiram)
Artane (Trihexyphenidyl)
Asendin (Amoxapine)
Ativan (Lorazepam)
Aventyl (Nortriptyline)
Benadryl (Diphenhydramine)
Benztropine
Bupropion
Buspar (Buspirone)
Buspirone
Calan (Verapamil)
Calcium Carbimide
Carbamazepine
Carbolith (Lithium)
Celexa (Citalopram)
Chlordiazepoxide
Chlorpromazine
Cibalith-S (Lithium)
Citalopram
Clomipramine
Clonazepam
Clopixol (Zuclopenthixol)
Clozapine
Clozaril (Clozapine)
Cogentin (Benztropine)
Cylert (Pemoline)
Cymbalta (Duloxetine)
Dalmane (Flurazepam)
Depakene (Valproate)
Depakote (Divalproex)
Desipramine
Desyrel (Trazodone)
Dexedrine (Dextroamphetamine)
Dextroamphetamine
Diazapam
Dilantin (Phenytoin)
Divalproex
Diphenhydramine
Disulfiram
Doxepin
Duloxetine
Duralith (Lithium)
Edronax (Reboxetine)
Effexor (Venlafaxine)
Elavil (Amitriptyline)
Endep (Amitriptyline)
Epitol (Carbamazepine)
Epival (Divalproex)
Eskalith (Lithium)
Ethosuximide
Etrafon (Perphenazine)
Fluanxol (Flupenthixol)
Fluoxetine
Flupenthixol
Fluphenazine
Flurazepam
Fluvoxamine
Halcion (Triazolam)
Haldol (Haloperidol)
Haloperidol
Imipramine
Imovane (Zopiclone)
Inderal (Propranolol)
Isoptin (Verapamil)
Janimine (Imipramine)
Klonopin (Clonazepam)
Lamotrigine
Lamictal (Lamotrigine)
Largactil (Chlorpromazine)
Libritabs (Chlordiazepoxide)
Librium (Chlordiazepoxide)
Lithane (Lithium)
Lithium
Lithizine (Lithium)
Lithobid (Lithium)
Lithonate (Lithium)
Lithotabs (Lithium)
Lorazepam
Loxapac (Loxapine)
Loxapine
Loxitane (Loxapine)
Ludiomil (Maprotiline)
Luvox (Fluvoxamine)
Manerix (Moclobemide)
Maprotiline
Mellaril (Thioridazine)
Mesoridazine
Methylphenidate
Moclobemide
Modecate (Fluphenazine)
Mysoline (Primidone)
Nardil (Phenelzine)
Navane
Nefazodone
Niravam (Alprazolam)
Norpramine (Desipramine)
Nortriptyline
Nozinan
Olanzapine
Orap
Oxazepam
Pamelor (Nortriptyline)
Parnate (Tranylcypromine)
Paroxetine
Paxil (Paroxetine)
Pemoline
Permitil (Fluphenazine)
Perphenazine
Pertofrane (Desipramine)
Phenelzine
Piportil (Pipotiazine)
Pipotiazine
Primidone
Prolixin (Fluphenazine)
Propranolol
Protriptyline
Prozac (Fluoxetine)
Quetiapine
Reboxetine (Edronax)
Restoril (Temazepam)
Rhotrimine (Trimipramine)
Risperidal (Risperidone)
Risperidone
Ritalin (Methylphenidate)
Rivotril (Clonazepam)
Sabril (Vigabatrin)
Serax (Oxazepam)
Serentil (Mesoridazine)
Seroquel (Quetiapine)
Sertraline
Serzone (Nefazodone)
Sinequan (Doxepin)
Stelazine (Trifluoperazine)
Sulpiride
Surmontil (Trimipramine)
Symbyax (fuoxetine/olanzapine)
Symmetrel (Amantadine)
T-Quil (Diazapam)
Tegretol (Carbamazepine)
Temazepam
Temposil (Calcium Carbimide)
Thioridazine
Thiothixene
Thorazine (Chlorpromazine)
Tofranil (Imipramine)
Trazodone
Triazolam
Trifluoperazine
Trihexyphenidyl
Trilafon (Perphenazine)
Trimipramine
Triptil (Protriptyline)
Valium (Diazapam)
Valium Injection (Diazapam)
Valproate
Valproic acid
Valrelease (Valproate)
Venlafaxine
Verapamil
Vivactil (Protriptyline)
Vigabatrin (Sabril)
Wellbutrin (Bupropion)
Xanax (Alprazolam)
Xanax XR (Alprazolam)
Zarontin (Ethosuximide)
Zoloft (Sertraline)
Zopiclone
Zuclopenthixol
Zyprexa (Olanzapine)