Turner Consulting & Therapy Services

Behavioral Health Questionnaire

Name _____ Age _____ Date _____

Marital Status _____ Occupation _____

Children _____ Who currently lives in your household? _____

Who referred you here, or where did you hear about us?

_____

_____

Present History

Describe the reason for your visit today:

_____

_____

_____

Are you currently depressed….. Yes No

Have you had past episodes of depression….. Yes No

Describe any **current** symptoms that you have regarding the following:

Sleep _____

Appetite _____

Mood/crying spells _____

Irritability/mood swings _____

Anxiety/Panic attacks _____

Energy/Motivation _____

Interest in normal activities _____

Guilt feelings _____

Libido _____

Concentration/Memory _____

Hearing Voices _____

Paranoia _____

Do you presently have suicidal thoughts?..... Yes No

Have you ever had suicidal thoughts?..... Yes No

Have you ever attempted suicide?..... Yes No
Do you or have you had homicidal thoughts?..... Yes No
Do you have blood relatives who have committed suicide?..... Yes No

Please list the stress in your life:

_____

_____

_____

Please list your **current psychiatric** medications.

Medication Dose How long? Side effects
Medication Dose How long? Side effects
Medication Dose How long? Side effects
Medication Dose How long? Side effects

Past Psychiatric History

Prior Psychiatrists _____
Past Therapists _____
When/Why? _____
Current Therapists

Have you ever been **hospitalized** in the past for any **psychiatric** reason?
Please list. Include Alcohol or Drug Treatments.

Date Place Reason
Date Place Reason
Date Place Reason

Please List **all psychiatric medications** that you have tried in the past. This includes any medications taken for your nerves, anxiety, depression, or insomnia, such as Prozac, Paxil, Zoloft, Celexa, Lexapro, Effexor, Pristiq, Cymbalta, Wellbutrin, Buspar, Remeron, Trazodone, Elavil, Luvox, Xanax, Klonopin, Valium, Ativan, Risperdal, Zyprexa, Seroquel, Abilify, Geodon, Lithium, Depakote, Tegretol, Trileptal, Lamictal, Neurontin, Topamax, Ambien, Lunesta, Rozerem, Restoril, Adderall, Concerta, Ritalin, Focalin, Vyvanse, Strattera, Provigil, Namenda, Aricept.

Medication and dosage	**When/How long?**	**Did it help?**	**Reason for stopping or side effects**

Are you frequently nervous or anxious? Yes No
Are you a worrier? Yes No
Do you have panic attacks or hyperventilation? Yes No
Have you had panic attacks in the past? Yes No
Have you had a fear or objects or situations? Yes No
Do you do a lot of hand washing or going back and checking doors, stoves, lights, etc.? Yes No
Are you bothered by recurrent nightmares or flashbacks from a previous traumatic event? Yes No

How much alcohol do you drink?(quantitate)
Are alcohol or drugs currently a problem? Yes No
Has alcohol or drugs ever been a problem? Yes No
Have you ever had a DUI or blackout? Yes No
Have loved ones been concerned about your alcohol/drug use? Yes No
Do you have any blood relatives with alcohol/drug problems? Yes No
Have you ever been arrested? Yes No

Have you had an eating disorder or caused yourself vomit or lose weight? Yes No

Medical History
Please list any medical problems or diagnoses that you have?

Any history of head trauma?	Yes	No
Any history of seizures?	Yes	No
Any history of developmental disorder?	Yes	No
Do you smoke	Yes	No
If Yes, how much and for how long?		
If quit, when?		
Do you exercise regularly?	Yes	No
For women:		
Do you still have regular periods?	Yes	No
Do you use birth control?	Yes	No
Are you taking any hormones?	Yes	No

Please give the name of your primary care doctor?

Name _____

Address _____

Phone No. _____

Please give the name of any other medical doctor from whom you receive regular treatment

Name	Specialty
Name	Specialty

Medical/Surgical Hospitalizations:

Date	Reason
Date	Reason
Date	Reason
Date	Reason

Please list all current medications:

Name	Dose	Reason taking
Name	Dose	Reason taking
Name	Dose	Reason taking
Name	Dose	Reason taking
Name	Dose	Reason taking
Name	Dose	Reason taking
Name	Dose	Reason taking
Name	Dose	Reason taking
Name	Dose	Reason taking
Name	Dose	Reason taking

Are you allergic to any medications? Yes No

Medication Reaction

Medication Reaction

Medication: Reason

Family/Social History

Who in your family has a psychiatric history?
Include history of alcohol or drug problem.

Relationship: _____ Problem: _____

Relationship: _____ Problem: _____

Relationship: _____ Problem: _____

Relationship: _____ Problem: _____

Social History: _____

Where were you born and raised? _____

Were you raised by your biological parents? Yes No

If no, describe:

_____

Do you have siblings? Yes No

Significant religious/cultural beliefs :

_____

Primary emotional sources of support: _____

Have you ever been physically, emotionally,
or sexually abused? Yes No

Please list any significant losses or deaths in your life:

Date _____ Description

Date _____ Description

Date _____ Description

Date _____ Description

Education _____

Work History _____

Are you currently married? Yes No If yes, how long? _____

Are you having any marital or relationship problems? Yes No If yes, describe:

_____

If you have children, do they have any significant psychiatric:
or medical problems? Yes No If yes, describe:

_____

Previous marriages? Yes No If yes, answer below

When _____ How long? _____ Reason for divorce/separation

_____

When _____ How long? _____ Reason for divorce/separation

_____

SIGNATURE: _____ **DATE**: _____