

Connecticut Psychiatric Partners, P.C.

HISTORY QUESTIONNAIRE

Today's Date: _____

Full Name: _____ Date of Birth: _____

Name of person completing this form & relationship: _____

CONTACT INFORMATION

Address: _____

Occupation: _____

Phone#: _____

Relationship Status: _____

What are the main concerns you have?

Race and Religion: _____

Are you adopted? Yes _____ No _____

Other people in the family:

Name	Gender	Date of Birth	Age	Relationship
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Other persons living in the home (significant other, friend, grandparents, foster child, etc) _____

Languages spoken in the home: _____

Agencies or professionals currently providing services to you and/or your family.

Agencies or professional	Age when services began
_____	_____
_____	_____
_____	_____
_____	_____

EDUCATION HISTORY

OCCUPATION HISTORY:

Longest employment: _____

FAMILY HISTORY

Please list any medical or psychiatric illness that runs in your family: _____

MEDICAL HISTORY

Health Care Providers:

Primary care physician name & address:

Phone: _____

Date of last complete physical examination: _____

Do you have any allergies (environmental, food/medication)? No _____ Yes _____ If yes, please list _____

Do you take any medications? No _____ Yes _____

(Include vitamins, over-the-counter drugs, and herbal medications)

Name	Dosage	Frequency	Date Began

Past medication trials: (Name/duration/effects)

Have you ever been hospitalized for any reason: No _____ Yes _____

If yes, describe:

Reason	Date	Place	Length of stay

Any history of self harm/suicide attempts:

Firearms in the house/access to firearms:

Do you have a current or past history of:

	No	Current	Past	List
Head injury				
Broken bones				
Surgeries				
Birth defects				
Poisoning (e.g.: lead)				
Heart problems				
Kidney problems				
Liver disease				
Lung disease				
Blood disease				
Cancer				
Seizure				
Other neurological problems (e.g.:headaches)				
Genetic disorder				

SUBSTANCE USE HISTORY

Tobacco use: type: _____ Amount: _____

Age started: ___ years Ongoing/ Age quit: ___ years

Any related illnesses/ withdrawals/ seizures/ hospitalizations:

Alcohol use: type: _____ Amount: _____

Age started: ___ years Ongoing/ Age quit: ___ years

Any related illnesses/ withdrawals/ seizures/ hospitalizations:

Cannabis use: type: _____ Amount: _____

Age started: ___ years Ongoing/ Age quit: ___ years

Any related illnesses/ withdrawals/ seizures/ hospitalizations:

Other Substance use/ experimentation:

Any history of intravenous drug use:

Yes ___ No ___

Any history of substance treatment:

Yes ___ No ___

If yes, please describe

SLEEP HABITS

What time do you generally go to bed? _____pm/am

What time do you generally wake up? _____pm/am

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

Do you snore or seem to gasp for air during the night? No_____ Yes_____

Shift work: Yes ___ No___

STRESSORS

Are you facing significant stressors at this time? No_____ Yes_____

If yes, please describe _____

Is your family facing any significant stressors just now? _____

Is there anything else you would like us to know that would assist us in understanding you?
