Piedmont Psychiatric Clinic

Dave M. Davis, M.D. F.A.P.A., F.A.B.F.P
Annie Cooper, M.D., F.A.B.P.N.
Tom Dixon, L.C.S.W.

PERSONAL HISTORY QUESTIONNAIRE

INSTRUCTIONS: This information is **CONFIDENTIAL.** The following information is very important to your health. Please take the time to answer these questions fully and accurately. If you do not wish to answer any questions, merely write "OMIT."

1. PERSONAL INFORMATION:

Last Name: _____First Name _____Middle Name_____ Age: ____ Sex: _____

Preferred or Nick Name that you would like to go by: _____

Marital Status: ____married ___ divorced ___ separated ___ common-law marriage

____living together ___never married ___spouse deceased ___number of marriages

Education level (highest grade you completed): _____ Occupation: _____ Number of children: _____

Name of Referring Physician or Agency: _____

Name and Specialty of Physicians/other Healthcare Providers you see regularly: _____

_____

_____**Please check here if you need to write additional Specialist / Physicians on page #10.**

List **all Allergies** and what type of reaction that you may have had to Medications or other Substances:

Medication	Type of Reaction	Age at time of Reaction
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any medicines you are currently taking or have taken during the past six months (including aspirin, birth control pills, hormone replacements or any other medicines that were prescribed or taken over the counter):

Name of Medicine(s)	Strength & Dosage (how much do you take & how often do you take your medication(s)	Purpose	Taken since (date)	Prescribed by Doctors Name:
Example: *40 mg, once a day or 40 mg twice a day*			*since 4/2001*	*Dr. Jones*
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

_____**Please check here if you need to write additional medications on page #10**

2. DESCRIPTION OF PRESENTING PROBLEMS State in your own words the nature of your main problems (why you came to see us):

_____

_____

_____

_____

_____

On the scale below, please estimate the severity of your problem(s):

Mildly Upsetting_____ Moderately Upsetting_____ Severe_____ Incapacitating_____

When did your problems begin (give dates)? _____

Please describe significant events occurring at that time, or since then, which may have contributed to the development or maintenance of your problems: _____

_____

What solutions to your problems have you tried? _____

_____

Have you been in therapy before or received any prior professional assistance for your problems? If yes, include marriage/sexual counseling, pastoral counseling, psychotherapy, and child/adolescent treatment, and / or family doctor:

Treating Professional	Profession	Purpose	Dates
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List all psychiatric hospitalizations, residential or day care treatment:

Hospital	Doctor	Purpose	Dates
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

_____**Please check here if you need to write additional hospitalizations, Etc. on page #10**

3. PERSONAL AND SOCIAL HISTORY

Date of Birth: _____ Place of Birth: _____ Adopted: ____Yes ____No

SIBLINGS (including 1/2 siblings and step siblings):

Number of brothers: _____ Name and Age of brothers: _____

Number of sisters: _____ Name and Age of sisters: _____

FATHER: Living? _____ If alive, give fathers' present age: _____

If deceased, give his age at time of death: _____

How old were you at the time of his death? _____ Cause of death: _____

His occupation(s) past or present: _____ Health: _____

MOTHER: Living? _____ If alive, give mothers' present age: _____

If deceased, give her age at time of death: _____

How old were you at the time of her death? _____ Cause of death: _____

Her Occupation(s) past or present: _____ Health: _____

How strong a force was religion in your family life as a child? (Circle one)

Very-strong Moderately-strong Mild Minimal None

How strong a force is religion in your life now? (Circle one)

Very strong Moderately-strong Mild Minimal None

Circle any of the following that occurred during your childhood/adolescence. Then in the space provided, write your age at the time the event occurred:

___Parental neglect	___Lack of Love	___Abandonment	___Financial Problems
___Happy Childhood	___Legal Trouble	___Physical Abuse	___Parental Remarriage
___Unhappy Childhood	___School Problems	___Medical Problems	___Frequent Moves
___Emotional/Behavior Problems	___Family Problems	___Parental Separation	___Parental Divorce
___Alcohol Abuse	___Drug Abuse	___Sexual Abuse	

___Raised by someone else other than parents ___Others (specify): _____

What sort of work are you doing now? _____

Have you ever been fired from a job: _____Yes _____ No

What kinds of jobs have you held in the past? _____

_____

Does your present work satisfy you? _____Yes _____ No

If not, please explain: _____

Do you have other means of income such as alimony, pension, disability, etc.? _____

What is your height? _____ ft. _____ inches. What is your weight? _____ lbs.

Have you ever been hospitalized for psychological problems or addiction treatment? _____ Yes _____ No

If yes, when and where? _____

_____

_____

Have you ever attempted suicide? _____Yes _____ No

Have you ever had recurring thoughts of suicide? _____ Yes _____ No

Has or does any member of your family (blood relatives) suffer from alcoholism, depression, or anything else that might be considered a "mental disorder"? _____

_____

Has any relative attempted or committed suicide? _____

4. INTERPERSONAL RELATIONSHIPS

Father: What was your father like to you? _____

How did he affect the way you felt about yourself? _____

How is your relationship with your father now? _____

Mother: What was your mother like to you? _____

How did she affect the way you felt about yourself? _____

How is your relationship with your mother now? _____

How is your relationship with significant other figures (grandparents, step parents, etc.) in childhood? _____

_____

Were you ever bullied or severely teased? _____

Rate the degree to which you generally feel comfortable and relaxed in social situations:

_____Very relaxed _____Relatively comfortable _____Relatively uncomfortable _____Very Anxious

Were you ever sexually, physically, verbally, or emotionally abused? _____

Generally, do you express your feelings, opinions, and wishes to others openly? _____ Yes _____ No

If we need someone, other than yourself, to give us history or background information on you, whom may we contact?

Name: _____ Address: _____ Phone number: Home)_____

Cell) _____

5. MARRIAGE or PARTNERSHIP: (If in Partnership, consider as "Spouse")

Number of Marriages _____ Divorces_____ Death of Spouses _____

Current spouse's / partner's name: _____

How long did you know your spouse before your engagement? _____ How long have you been married? _____

What is your spouse's age? _____ What is your spouse's occupation? _____

Describe your spouse's personality: _____

How would your spouse describe you? _____

In what areas are you compatible? _____

In what areas are you incompatible? _____

How do you get along with your in-laws (this includes brothers and sisters-in-law)? _____

Number of children: _____ Number of pregnancies: _____

Number of Abortions: _____ Number of Miscarriages: _____

Do you think there was, or may have been, inappropriate sexual behavior initiated toward you as a child? _____ Yes _____No

_____

Have there been sexual relationships which you feel were damaging to you? _____

Are there concerns presently in your life that relate to your sexuality or your present sexual relationship? _____

_____

6. LIST YOUR THREE MAIN FEARS:

(1)_____

(2)_____

(3)_____

7. PHYSICAL SENSATIONS:

Circle any of the following that often apply to you:

Headaches	Stomach trouble	Flushes	Don't like being touched
Dizziness	Tics/twitches	Skin problems	Excessive sweating
Palpitations	Fatigue	Dry mouth	Visual disturbances
Muscle spasms	Back pain	Chest pains	Hearing problems
Tension	Tremors	Burning/itchy skin	Sexual Problems
Fainting spells	Rapid heartbeat	Tingling/Numbness	Hear things
Blackouts	Chronic Pain		

Check any of the following stresses that have applied to you over the past 12 months:

_____Divorce or separation	_____ Problems with Parents	_____Problems with money
_____Having to care for aging relatives	_____Problems with children	_____Problems with spouse
_____Death of a close family member	_____Son or daughter leaving home	_____Problems with neighbors
_____Personal illness or injury	_____Trouble with in-laws	_____Problems with Co-workers
_____Marriage	_____Change in residence	_____Change in eating habits
_____Changes in my work	_____Change in sleeping habits	_____Problems with sex

_____Other: _____

Are your menstrual periods regular? _____

Do you have pain/cramps during your before, during or after your period? _____

Do your periods affect your mood? _____

How much alcohol do you drink per week? _____If you quit, when? _____

How much tobacco do you use per week? _____ If you quit, when? _____

Have you used recreation/illegal drugs? Yes _____ No _____ If yes, at what age(s)? _____

Describe _____

If you have quit, when? _____

8. THOUGHTS

What do you consider to be your most irrational thought or idea? _____

Are you bothered by thoughts that occur over and over again? _____ Yes _____ No

_____

9. LEGAL

Circle any that apply to you:

Jailed	Bankruptcy	Been sued
IRS problems	Paternity suit	Filed lawsuit
Juvenile Court	Arrests	Workers Compensation
Crime victim	Disability	Victim of violent crime
Truancy	DUI	Suspended driver's license
Conviction	Prison	Used illegal substance(s)
Fired from job	Fighting	Carry a weapon
Destroy property	Animal cruelty	Irresponsible parenting
Child Abuse	Fire setting	Shoplifted/theft/stealing
Rape	Sexual harassment	Sexually transmitted disease
Pornography	Computer Addiction	Excessive Phone
Excessive Text Use	Texting while Driving	Pay Garnished

10. **HEALTH**

Do you eat three well-balanced meals each day? _____Yes _____No

If not, please explain: _____

Do you get regular physical exercise? _____Yes _____No If so, what type and how often? _____

Do you have any current concerns about your physical health? Please specify: _____

_____

_____

A.) Have you had a Colonoscopy? _____Yes _____No

B.) Have you had a Prostate Screening? _____Yes _____No

C.) Have you had a Mammogram? _____Yes _____No

Check your experience of the following:

	Never	Rarely	Freq.	Often
Prescription drugs				
Non-Prescription drugs				
Alcohol				
Coffee				
Cigarettes				
Diarrhea				
Constipation				
Allergies				
High blood pressure				
Heart problems				
Vomiting				
Insomnia				
Headaches				
Backache				
Sleep difficulties				
Problems with eating				

List all major illnesses you have had and dates:

_____

_____

_____

_____

_____**Please check here if you need to write additional medications on the reverse side of this page**

Circle any of the following that apply to you:

Thyroid disease	Infectious diseases	Prostate problems	Kidney disease	Gastrointestinal disease
Asthma	Cancer	Epilepsy	Neurological disease	Blood disease
Diabetes	Glaucoma	Gynecological	Lung disease	Sexually transmitted disease
High Blood Pressure		Other: _____		

_____

List all medical/surgical hospitalization:

Name of Hospital & Location (City/State)	Reason for Hospitalization/Surgery	Treating Doctor	Date

_____Please check here if you need to write additional medications on the reverse side of this page

Have you ever had any head injuries or loss of consciousness? _____Yes _____No

Please give details: _____

Please describe any accidents or injuries you have suffered (give dates): _____

_____

_____

_____

Have you had a bad experience with a doctor or other healthcare person? _____Yes _____No

If yes, please explain: _____

_____

_____

_____

***IF YOU HAVE LEFT ANY QUESTIONS BLANK, PLEASE GO BACK AND COMPLETE THEM!**

The above information is true and correct.

PATIENT'S SIGNATURE _____ **DATE** _____