Crystal Run Healthcare

155 Crystal Run Road
Middletown, NY 10941
845-703-6999

61 Emerald Place
Rock Hill, NY 12775
845-794-6999

Patient Information Questionnaire - Psychiatry

Thank you for allowing us to be part of your healthcare team. We look forward to working with you to provide the best possible care. Please take a few minutes to complete this form prior to your first appointment. We realize that this is a lot of information and some of it is very personal, but do your best.

Date: _____

Patient Name: _____ DOB: _____

Physical Address: _____

What issues are you seeking help for? _____

How long have these problems existed? _____

Current life stressors? (Please circle)
Home Work Health Family Relationships Education

Who referred you here? _____

Past Psychiatric/Mental Health History:

Previous psychiatric diagnosis: _____
Previous Psychiatrist(s): _____
Previous therapist(s) or counselor(s) and for what duration: _____
Previous psychiatric hospitalization(s) and when: _____
Previous outpatient treatment programs: _____
Previous suicide attempt(s), self-harm, or suicidal thoughts: _____
Previous alternative or complementary treatments (examples are herbs, special diets, acupuncture, etc.): _____

Previous psychiatric medications:

Name	Dose	Frequency	Start Date	Stop Date	Was the medication helpful?

Medical History:

Current and Past Medial Problems: _____
_____
_____
_____

Prior Hospitalizations: ☐ Yes ☐ No Date/Reason: _____
Surgery History (Date/Reason): _____

History of a head injury: ☐ Yes ☐ No

History of seizures: ☐ Yes ☐ No Last known seizure: _____

How would you describe your health habits (diet, exercise, sleep, etc.)? ☐ Healthy ☐ Unhealthy

Are you interested in receiving education and resources for healthy lifestyle changes?
☐ Yes ☐ No

Amount of caffeine consumed per day (coffee, tea, soda, chocolate, energy drinks, etc): _____

Current Medications including supplements:

Name	Dose	Frequency	Start Date	Treatment for ___?___

How often do you have trouble taking your medications as prescribed?
☐ Often ☐ Sometimes ☐ Never

Drug Allergies: _____

Food Allergies: _____

Substance Use History

	Currently Using	How Much	How Often	Previous Use	Age at First Use	Previous Treatment
Marijuana						
Alcohol						
Tobacco						
Cocaine/Amphetamines						
Benzodiazepines						
Opiates						
Hallucinogens						
Other_____						

Family members with substance abuse or dependence: _____

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Developmental History:

Age of Mother at birth:_____ Age of Father at birth: _____

Delivery: ☐ Vaginal ☐ Caesarean Section

Were pregnancy and delivery normal? ☐ Yes ☐ No
If No, please explain: _____
Time spent in nursery: _____
Time spent in NICU: _____

Term of Pregnancy: _____weeks
Birth Weight: _____lbs._____oz.

Exposure to substances in utero (alcohol, drugs, medications, etc.): _____
_____

Indicate age at each milestone:

Milestone	Age
Smile	
Sat alone	
Crawl	
Stand	
Walk	
Climb Stairs	
First Words	
First Sentence	
Feed Self	
Dress Self	

Milestone	Age
Bladder Control	
Bowel Control	
Throw a ball	
Ride a bike	
Tie Shoes	
Use a Pencil	
Puberty	
Drive a car	
First Peer Group	
First Romantic Relationship	

If you are an adult, please indicate whether you ever had a problem with the following. If you are a parent, please indicate if your child has ever had a problem with the following:

Problem	No	Yes	At what age?	How long did it last?
Fears				
Head Banging				
Thumb Sucking				
Teeth Grinding				
Toilet				
Bed or Clothes Wetting				
Sleep				
Attention Span				
Physical Aggression				
Property Destruction				
Eating or Food				
Weight				
Temper Tantrums				
Fire Setting				

Problem	No	Yes	At what age?	How long did it last?
Baby Talk				
Being a Mama's Boy				
Being a Daddy's Girl				
Sexual Difficulties				
Masturbation				
Separation				
Unusual Habits or Interests				
Cutting or Burning Self				
Moody or Irritable				
Excessive Crying				
Cussing				
Friends or Fitting-in				
Worry				
Skin Picking				
Hair Pulling				

Family History

	Name	Age	Occupation or Student	Highest Grade Completed	Medical History	Mental Health History (diagnosis and treatment)
Mother						
Father						
Sibling						
Sibling						
Sibling						
Maternal Grandmother						
Maternal Grandfather						
Paternal Grandmother						
Paternal Grandfather						
Aunts/Uncles						
Son(s)						
Daughter(s)						

Abuse History

Sexual Abuse: ☐ Yes ☐ No
Physical Abuse: ☐ Yes ☐ No
Emotional Abuse: ☐ Yes ☐ No
Neglect: ☐ Yes ☐ No
Trauma (witnessed or experienced): ☐ Yes ☐ No

Social History

Relationship Status: ☐ Single/Never Married ☐ Divorced ☐ Married ☐ Separated ☐ Widowed

Previous marriages _____
Children (sex and ages) _____

Sexually active: ☐ Yes ☐ No

Education History:

Highest level completed _____
Name of school _____
Average grades received _____
Repeated or skipped grades _____
Learning Disabilities _____
Special services (IEP, 504 plan, Resource Room, etc.) _____
Issues in school (bullying, detention, in-school suspensions, expulsions, peer relationships, fighting, etc.) _____

Employment History:

Current: _____
Prior suspensions, terminations, or voluntary leave? _____

Living environment: ☐ House ☐ Apartment ☐ Shelter ☐ Staffed Residence
☐ Other _____

Who lives in the home? _____
Pets? _____

Military History: _____

Legal History (examples are speeding tickets, jail/prison, charges, CPS involvement etc.): ___

_____

Religious, Spiritual, or Cultural Preferences: _____

Hobbies: _____

Anything else we should know about you?_____