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: ______________________

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: ______________________________

Crystal Run Healthcare

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

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

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: ______________

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

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

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				

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)						

Crystal Run Healthcare

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

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

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? ___________________________