North Atlanta Psychiatry

Initial Assessment – Health Questionnaire

Date: ______________________

Patient Identifying Information			
Last Name:	First Name:		
Date of Birth:			
Religion			
☐ Protestant	☐ Catholic	☐ Jewish	
☐ Muslim	☐ Hindu	☐ Other	
Residence			
☐ House	☐ Apartment	☐ Room	
☐ Dormitory	☐ Hotel	☐ Hospital	☐ Other
Education			
☐ High school and earlier	Highest Grade___________________________		
☐ College\University	Years of college _________________________		
☐ Graduate School	Degree(s) ______________________________		

Main problem that brought you to the doctor
Describe Main Symptoms

When did the problems first begin?

Describe any stress in your life that may have contributed to the problem:

Please check the statement below that best describe the course of the problems since they began:
☐ The problems have stayed about the same since they started ☐ The problems have steadily worsened since they started ☐ The problems seem to come and go ☐ The problems have ups and downs but haven't gone away completely since they started

Prior History for this problem
Have you had a past experience in which you had similar problems? ☐ Yes if yes, when ______________________________ ☐ NO Were you treated for this problem? ☐ Yes if yes, treatment received ______________________________ ☐ NO

Areas worsened due to current problems	
Check all the areas worsened due to your current problems:	
☐ My school/work performance	☐ My relationship with my friends
☐ My relationship with my family	☐ My ability to manage my usual chores at home
☐ My interest in keeping up my appearance	☐ My ability to get along with my parents/children
☐ My ability to control my temper	☐ My ability to control my behavior.
☐ My ability to carry out my usual leisure interests	☐ My relationship with employer or co-workers
☐ My ability to plan and set goals for my future	☐ My relationship with legal authorities.

North Atlanta Psychiatry

Suicide

Did you ever thought about suicide?

☐ Yes - if yes, when ________________________ ☐ NO

Have you ever attempted suicide?

☐ Yes - if yes, when and how ________________________ ☐ NO

Are you having any suicidal thoughts now? ☐ Yes ☐ NO

Injury to Others

Did you ever thought about hurting someone?

☐ Yes - if yes, when ________________________ ☐ NO

Have you ever hurt someone else?

☐ Yes - if yes, when and how ________________________ ☐ NO

Are you thinking about hurting someone now? ☐ Yes ☐ NO

Personal History

Check any items that apply to you and explain:

☐ Mother's pregnancy with you was abnormal: How________________________
☐ Mother' s delivery of you was abnormal: How________________________

Check all that apply --- Check if during childhood you →

☐ were afraid to go to school
☐ were truant
☐ had frequent falls
☐ wet bed after age 5
☐ had trouble with eyes
☐ were/are left handed
☐ ran away from home
☐ were cruel to animals
☐ often lied to families or others
☐ were promiscuous
☐ had difficulty with reading, writing, or math
☐ failed or repeated a grade
☐ had night mares, disturbed sleep, fear of the dark
☐ were awkward at games
☐ had tics
☐ mispronounced words, had a list, stutter/stammer
☐ set fires
☐ moved often
☐ were exposed to incest
☐ Other ________________________

North Atlanta Psychiatry

Social History

Married? ☐ Yes ☐ NO Divorced? ☐ Yes, # of marriages ______ ☐ NO

Children? ☐ NO ☐ Yes, Ages________________________________ # living with you ________

Do you smoke cigarettes? ☐ NO ☐ Yes, How many per day ? __________________

Do you currently use any type of drugs? ☐ NO ☐ Yes If yes, what types of drugs and how much per day?____

Do you currently drink alcohol? ☐ NO ☐ Yes If yes, what type of alcohol and how much per day? ____

Any history of legal problems? ☐ NO ☐ Yes If yes, Please Specify ____________________

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Stressful or traumatic events

List any stressful or traumatic events in your life which may have affected your development and ability to function (i.e., birth of sibling, death in the family, divorce, illnesses, frequent school changes, witnessing a trauma etc)

Incident	Age	Comments

Medical History

Height ________________ Weight________________

Current Medication	Dose	Times/Day	Comments

North Atlanta Psychiatry

Allergies to Medication	
Medication	**Type of reaction.**

Surgeries		
Surgery	**Age**	**Complications**

Hospitalizations		
Age	**Reason**	**Length of Stay**

Head Injuries		
Age	**Type of Injury**	**Loss of Consciousness**
		☐ Yes ☐ NO
		☐ Yes ☐ NO
		☐ Yes ☐ NO
		☐ Yes ☐ NO
		☐ Yes ☐ NO

Current Medical Health Status

☐ **Excellent** ☐ **Good** ☐ **Fair** ☐ **Poor** **Comments/List current health conditions:** ____

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North Atlanta Psychiatry

Family History		
Provide information of family members suffering from mental health problems or medical problems.		
Indication	**Family Member(s)**	**Comments/Medications/Hospitalizations**
Depression		
Bipolar Disorder		
Anxiety Disorder		
Schizophrenia		
Eating Disorder		
Anorexia/Bulimia		
Learning Disorder		
Substance Abuse		
Alcohol/Drugs		
ADHD		
Suicide attempt or Completion		
OCD/Obsessive		
Compulsive Disorder		
Legal Problems		
Violent Behavior		
Speech Problems		
Tourettes/tic Disorder		
Obesity		
Heart Problems		
High Cholesterol		
Epilepsy/Seizures		
Thyroid Problems		
Other: specify _________ ________________________		