Puget Sound Psychiatric Center, P.S.

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Patient's Name:	_____
DOB:	_____
Date:	_____

- Please take a moment of your time to fill out the following information as it will help the doctor in the initial assessment.
- Filing out this questionnaire will also help in identifying treatment goals.
- Please not all information pertains to the patient.

1. Please describe **your (the patient's) PRIMARY TREATMENT GOAL** of seeking psychiatric consultation:

2. Please describe what you (the patient) need help with:

3. Have you (the patient) ever consulted a **PSYCHIATRIST** before? If yes, please give us the name and address of the psychiatrist and the approximate that dates that you saw the psychiatrist. We will also ask you to sign consent to exchange information. However you do have the right to refuse to give consent for contact.

4. Are you or have you (the patient) ever been **in THERAPY/COUNSELLING**? If yes, please give us the name and address of the counselor and the approximate that dates of therapy. We will also ask you to sign consent to exchange information. However you do have the right to refuse to give consent for contact.

5. Are you (the patient) currently taking ***PSYCHIATRIC MEDICATIONS*** or have you ever taken medications in the past? If yes please give us the names and the exact dosages of the medications that you take.

6. Do you (the patient) currently use **SUBSTANCES** or have in the past used any substances. Please also list if you have ever been habituated to or addicted to any medication/prescription drug or street drugs. Have you ever been in any Chemical dependency treatment setting (either inpatient or outpatient)?

7. Please provide the name of your(the patient's) **PRIMARY CARE PHYSICIAN** (primary prescribing nurse practitioner). When was your most recent physical examination? When was the last time you had a lab exam?

8. Do you (the patient) have any **ALLERGIES TO MEDICATIONS**? environmental agents or any other agents? If yes please give us a detailed list of all known agents that you are allergic to.

9. Do you (the patient) have any **CURRENT AND ACTIVE MEDICAL PROBLEMS**? If yes please give all details possible, including when diagnosed, current treatment etc.

10. Have you (the patient) ever had any **PREVIOUS MEDICAL CONCENRNS** that no longer need treatment or monitoring? Please give details of the conditions and how treated and cured?

11. Is there **a FAMILY HISTORY OF PSYCHIATRIC ILLNESSES**, please describe any psychiatric conditions exist biological maternal and paternal families. Please also describe if there is any history of substance use or abuse in the family. Any history of suicidal gestures, attempts or completion should also be listed.

12. Is there **a FAMILY HISTORY OF MEDICAL PROBLEMS** in either your maternal or paternal family?

13. Is there any history of **ABUSE OR TRAUMA** that you (THE PATIENT) have suffered in the past? If yes please describe how it effects your functioning at present and if you have been in treatment for it in the past or are in treatment at present.

14. Please describe if you (the Patient's) have ever been in any **LEGAL PROBLEMS** (if applicable).

15. Please describe your (The Patient's) **EDUCATION AND OCCUPATION** (as applicable); please give details if schooling has been or is a problem; or if you are experiencing problems in your occupation.

16. Please describe your (The Patient's) **SOCIAL HISTORY** such as your current housing/living situation, and relationships. Please include an account of your immediate family, parents, siblings and children (as applicable); please also give an account of social supports, friends, significant relationships etc.

17. Please tell us if there are **other concerns that are important** to you that have not been addressed in the questions above.