

## Puget Sound Psychiatric Center, P.S.

10634 E Riverside Drive, Suite 130 Bothell, WA. 98011 Tel: (425) 806-5021 Fax: (425) 486-3949

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.

2.

Please describe consultation:	your (the	patient's)	PRIMARY	TREATMENT	GOAL	of	seeking	psychiatric
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Please describe v	vhat you (the	patient) nee	d help with:					

name and address of the counselor and the approximate that dates of therapy. We will also ask you to consent to exchange information. However you do have the right to refuse to give consent for contact.  Are you (the patient) currently taking <i>PSYCHIATRIC MEDICATIONS</i> or have you ever taken medicain the past? If yes please give us the names and the exact dosages of the medications that you take.  Do you (the patient) currently use <b>SUBSTANCES</b> or have in the past used any substances. Please also	to sig	gn consent to	exchange inf	ormation. Ho	wever you do	nave the right t	o refuse to g	give consem	lor cor
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Do you (the patient) have any ALLERGIES TO MEDICATIONS? environmental agents or any agents? If yes please give us a detailed list of all known agents that you are allergic to.  Do you (the patient) have any CURRENT AND ACTIVE MEDICAL PROBLEMS? If yes please give details possible, including when diagnosed, current treatment etc.  Have you (the patient) ever had any PREVIOUS MEDICAL CONCENRNS that no longer need treator monitoring? Please give details of the conditions and how treated and cured?	naciiione	r). When was yo	our most recen	o prinjerour on			idst tillie you	i iiaa a iao c
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11.	Is there <b>a FAMILY HISTORY OF PSYCHIATRIC ILLNESSES</b> , 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 <u>a FAMILY HISTORY OF MEDICAL PROBLEMS</u> in either your maternal or paternal family?
13.	Is there any history of <u>ABUSE OR TRAUMA</u> 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 <u>LEGAL PROBLEMS</u> (if applicable).
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Please describe your (The Patient's) SOCIAL HISTORY such as your current housing/living situation relationships. Please include an account of your immediate family, parents, siblings and children applicable); please also give an account of social supports, friends, significant relationships etc.  Please tell us if there are other concerns that are important to you that have not been addressed in questions above.	Please describe your (The Patient's) <b>EDUCATION AND OCCUPATION</b> (as applicable); please g details if schooling has been or is a problem; or if you are experiencing problems in your occupation.
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