

PSYCHIATRIC DISORDERS QUESTIONNAIRE

To be completed by the treating physician
(PLEASE USE BLOCK LETTERS)



1. PATIENT'S INFORMATION

Name	Last	First	M.I.
Date of birth	MM / DD / YY		

2. MEDICAL INFORMATION

Diagnosis (PLEASE MARK ALL THAT APPLY)

<input type="checkbox"/> Generalized anxiety	<input type="checkbox"/> Obsessive-compulsive disorder	<input type="checkbox"/> Panic syndrome
<input type="checkbox"/> Mild or moderate depression	<input type="checkbox"/> Bipolar disorder	<input type="checkbox"/> Schizophrenia
<input type="checkbox"/> Major depression	<input type="checkbox"/> ADHD / ADD	<input type="checkbox"/> Other

Please describe patient's symptoms, how often they occur, severity, and current status:

Date of first symptom	
MM / DD / YY	
Date of last symptom	
MM / DD / YY	

Is or was the patient taking any medication for this condition? Yes No If "Yes", please provide name of medication, dosage and frequency of use.

Start date	
MM / DD / YY	
Stop date	
MM / DD / YY	

Does the patient visit a doctor/psychiatrist for this condition? Yes No If "Yes", please indicate frequency.

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Has the patient received counseling or therapy for this condition? Yes No If "Yes", please indicate frequency and date of last session.

	Date	MM / DD / YY
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What other treatments has the patient received for this condition? (PLEASE MARK ALL THAT APPLY)

Date	Treatment
MM / DD / YY	<input type="checkbox"/> Emergency room visit(s)
MM / DD / YY	<input type="checkbox"/> Hospitalization
MM / DD / YY	<input type="checkbox"/> In-patient treatment
MM / DD / YY	<input type="checkbox"/> Other

Has the patient ever had any suicidal ideation or any suicide attempts? If "Yes", please provide date. Yes No

Date	MM / DD / YY
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