# Beacon Behavioral Health Associates, PLLC

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## INITIAL PSYCHIATRIC VISIT SELF-QUESTIONNAIRE

**All information is kept in your CONFIDENTIAL medical record and will not be released without your consent. Please read and complete all sections and initial pages.**

**Name: _____ DOB: _____**

**HISTORY OF CURRENT PROBLEMS/ISSUES**

**Please describe what problems you are having that led you to seek psychiatric services?**

_____
_____
_____
_____

**What are your goals of treatment?**

_____
_____
_____

**MEDICAL HISTORY**

**Are you currently taking any medications? List ALL current medications: include any prescription medications, inhalers, over the counter medications, birth control pills, vitamins, herbal supplements, dietary supplements, etc. Please bring all prescription bottles with you to your first appointment.**

**Name Dose Times per day**
**Reason**_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

**Do you have any allergies to any medications, foods, latex, environmental substances, or other substances □YES □ NO. If yes, please list all allergies and the allergic reaction(s) experienced.**

_____
_____
_____
_____

**<u>PHYSICAL HEALTH SCREENING:</u>**
**Currently or in the past, any problem/diagnosis/treatment procedure regarding any of the following?**
**Please check (X) to all that apply.**

| CURRENT | PAST | |
|---|---|---|
| | | Shortness of breath |
| | | Asthma |
| | | Frequent lingering cough |
| | | Blurred vision, glaucoma, or other vision issues |
| | | Concussion; head injury |
| | | Frequent severe headaches |
| | | Stroke |

| | | |
|---|---|---|
| | | **Sudden loss of smell, taste, vision, hearing, sensation** |
| | | **Seizures or convulsions** |
| | | **Motor coordination/paralysis** |
| | | **Tics or tremors** |
| | | **Chest pain, chest palpitations, heart murmur, other heart issue** |
| | | **Bleeding issues (e.g. Low platelets)** |
| | | **Swelling of the hands & feet** |
| | | **Night sweats/ fevers** |
| | | **Dizziness/ fainting spells** |
| | | **Jaundice/hepatitis/other liver problems (e.g. elevated liver enzymes)** |
| | | **Increased thirst/urination** |
| | | **Cancer (within last 5 years)** |
| | | **High cholesterol** |
| | | **Skin problems** |
| | | **Joint/ back problems** |
| | | **Thyroid problems (e.g. Hypothyroidism, Hyperthyroidism, etc.)** |
| | | **High blood pressure** |
| | | **Diabetes** |
| | | **Kidney disease/stones** |
| | | **Blood disorders (e.g. Anemia, Decreased white blood cells, etc.)** |

| | | |
|---|---|---|
| | | **Arthritis** |
| | | **Sexually transmitted disease** |
| | | **Heart disease** |
| | | **Abdominal pain, chronic constipation and/or diarrhea** |
| | | **Ulcers** |
| | | **Unintentional weight loss/gain** |
| | | **Eating disorder** |
| | | **Hormone replacement therapy** |
| | | **Nutrition problems** |
| | | **Past surgeries:** |
| | | **Other:** |

**Please give additional details for any sections marked with Xabove**

_____
_____
_____
_____
_____
_____
_____

**<u>FOR WOMEN ONLY</u>**

**Are you pregnant? □YES □ NO**

**Are you currently using birth control? □YES □ NO**

**If yes, what form of birth control (e.g. oral contraceptive, IUD, implant, patch, ring, etc.) are you currently using?**

_____
_____

**FAMILY AND SOCIAL HISTORY**

**What is your primary language?**

**_____**

**Does anyone in your immediate or extended family have a history of mental health or substance/alcohol abuse issues (including suicide attempts or completed suicides)? □YES □ NO.**

**If yes, please give additional details:**

**_____**

**_____**

**_____**

**_____**

**_____**

**_____**

**CURRENT STATUS AND FUNCTIONING**

**What is your Sex: □ Female □ Male**

**Marital Status: _____**

**Do you have any children? □YES □ NO.**

**Who lives in your home?**

**_____**

**Do you feel safe in your home? □YES □ NO**

**What is the highest level of education you completed?**

**_____**

**Are you currently attending school? □YES □ NO. If yes, what school?**

**_____**

**Are you currently employed? □YES □ NO. If yes, current employer?**

**_____**

**What is your occupation?**

**_____**

**Do you own or have access to a gun? □YES □ NO. If yes, is gun kept locked up □YES □ NO**

**Have you been in the military? □YES □ NO. If yes, what branch of service?**

**_____**

**Have you ever been arrested? □YES □ NO. If yes, what charge?**

**_____**

**Are you followed by any agencies (e.g. DCF, DYS, DMH, etc)? □YES □ NO. If yes, what agencies?**

**_____**

**_____**

**_____**

**_____**

**SUBSTANCE USE HISTORY**

**Do you drink any alcohol? □YES □ NO.**

- **If yes, how often do you drink?**

**_____**

- **How many and what types of drinks do you have each time you drink?**

**_____**

**_**

- **Have you ever felt you should cut down on your drinking? □ yes □ no**
- **Have people annoyed you by criticizing your drinking? □ yes □ no**
- **Have you ever felt bad or guilty about your drinking? □ yes □ no**
- **Have you ever had a drink in the morning to steady your nerves or get rid of hangover symptoms (eye-opener?) □ yes □ no**

**Do you smoke cigarettes or use other tobacco products? □YES □ NO. If yes # cigarettes per day _____**

**Please check any drugs that you currently use or have used in the past. On the lines provided, describe if current or past use, the frequency of use, and the reason for use**

**Cannabis:□ Hashish □ Marijuana □ Other**

**_____**

**_____**

**_____**

**_____**

**Depressants:□ Barbiturates □ Benzodiazepines (Valium, Xanax, Klonopin, Ativan, etc.) □ Other**

**_____**

**_____**

**_____**

**Hallucinogens:□ LSD (Acid) □ Mescaline □ PCP □ Mushrooms □ Other**

**_____**

**_____**

**_____**

**_____**

**Stimulants:□ Amphetamines (Ritalin, Concerta, Adderall, Vyvanse, etc) □ Ecstasy/Molly □ Cocaine □ Caffeine □ Guarana □ Pseuodoephedrine □ DXM**

**_____**

**_____**

**_____**

**_____Narcotics:□ Codeine □ Heroin □ Hydrocodone (Vicodin), Oxycodone (Percocet) □ Morphine □ Opium □ Darvocet □ Other**

**_____**

**_____**

**_____**

**_____**

**Other Substances_____**

**_____**

**LIFESTYLE HABITS**

**Do you have any special type of diet? □YES □ NO**

**Do you have any concerns about your weight? □YES □NO. If yes, explain_____**

**_____**

**_____**

**Have you restricted food, binged, and/or purged food either now or in the past? □YES □NO. If yes, please give details_____**

**_____**

**How many hours do you generally sleep during a 24-hour period?**

**_____**

**Do you have any trouble falling asleep? □YES □ NO**

**Do you have any trouble staying asleep? □YES □ NO**

**MENTAL HEALTH HISTORY**

**Have you ever been in therapy and/or substance abuse counseling? □YES □ NO. If yes, please give reasons for therapy and/or substance abuse counseling.**

**_____**

**_____**

**_____**

**Have you been diagnosed with any psychiatric disorders (e.g. depression, anxiety disorder, bipolar disorder, ADHD, PTSD, psychosis, borderline personality disorder, etc.) previously by another provider? □YES □ NO. If yes, what disorder(s) have you been diagnosed with?**

**_____**

_____
_____
_____

**Have you ever had neuropsychological testing performed? □YES □ NO. If yes, please email or fax copy to our office (prior to your appointment) or bring a copy with you to your appointment.**

**Have you taken psychiatric medication in the past? □YES □ NO. If yes, please list all medications taken, dosages, response (did it work?), side effects, and reason stopped.**

_____
_____
_____
_____
_____
_____
_____

**Have you ever been hospitalized on an inpatient psychiatric unit for mental health or substance abuse issues? □YES □ NO. If yes, when, why and how long were you inpatient?**

_____
_____
_____
_____
_____

**Have you ever attended a partial hospitalization or dual diagnosis day program? □YES □ NO. If yes, where and when?**

_____
_____
_____
_____

**Any past or present suicidal thoughts, plans or attempts? □YES □NO. If yes, explain.**

_____
_____

**Any past or present thoughts about harming someone else? □YES □NO. If yes explain.**

**_____**

**_____**

**_____**

**_____**

**Do you have any history of the following events that have occurred to you during your lifetime? (Check all that apply)**

**□ Physical Abuse □ Verbal Abuse □ Witness to violence □ Teasing/Bullying**

**□ Sexual Abuse or Rape**

**□ Other Trauma (fire, victim or a crime, natural disaster, etc.)**

**_____**

**If you checked off any of the above, do you experience:**

**□ Nightmares**

**□ Flashbacks/reexperiencing**

**□ Get startled easily**

**□ Avoid situations that remind you of the event**

**□ Feel like you are always "on-guard" (hypervigilant)**

**□ Dissociate ("zone out", lose track of periods of time)**

**Now or in the past have you experienced problems with any of the following symptoms or behaviors?: (Check all that apply)**

**□ Feeling down or sad most of the time**

**□ Tearful or excessive crying**

**□ Little interest and pleasure in things**

**□ Fatigue**

**□ Prolonged decreased or increased appetite**

**□ Unintentional weight loss or weight gain**

**□ Problems falling asleep, staying asleep, or both**

**□ Sleeping too much**

**□ Low self-esteem**

**□ Feeling hopeless**

**□ Feelings of worthlessness**

**□ Decreased concentration**

**□ Suicidal thoughts?**

**- If yes please circle all that apply: Plans; Attempts; Impulse to carry out suicide; Intent to carry out suicide**

**□ Inflated sense of self-esteem or grandiosity**

**□ Feeling like your thoughts are racing (you can't keep up with the speed of your thoughts)**

**□ Decreased need for sleep (e.g. feel rested after only 3 hours of sleep)**

**□ Restlessness**

**□ Agitation**

**□ More talkative than usual or talking very fast**

**□ Impulsive spending or repeated spending sprees**

**□ Risky behavior (e.g. reckless driving, promiscuous sex, drug benders)**

**□ Intense irritability**

**□ Excessive anger**

**□ Repeated explosive outbursts**

**□ Distractible**

**□ Mood swings**

**□ Excessive anxiety or worry**

**□ Feel keyed up or on edge**

**□ Feeling "tense" all the time**

**□ Panic attacks**

**□ Social anxiety**

**□ Fear of leaving your home**

**□ Excessive handwashing (greater than 10 times per day)**

**□ Checking behaviors, counting, positioning things, or things "just don't feel right"**

**□ Hair pulling**

**□ Skin picking**

**□ Tendency to fixate on things**

**□ Hoarding behavior**

**□ Intrusive thoughts**

**□ Feelings of guilt or shame**

**□ Feeling generally detached from others**

**□ Fear of being abandoned**

**□ Feelings of emptiness**

**□ Self-harm (cutting, burning, etc)**

**□ Using illegal drugs or prescription drugs without a valid prescription**

**□ Excessive use of alcohol**

**□ Blackouts**

□ **Memory disturbances**
□ **restricting food intake**
□ **Self-induced vomiting**
□ **Laxative abuse**
□ **Odd or irrational behavior**
□ **Tics or involuntary movements**
□ **Aggressive or violent behavior**
□ **Fire-setting**
□ **Inattentiveness**
□ **Often make careless mistakes failing to give close attention to details**
□ **Mind often wanders**
□ **Often start things but do not follow through and finish things**
□ **Difficulty organizing tasks**
□ **Often find yourself losing things necessary to complete tasks**
□ **Often forgetful in daily activities**
□ **Feeling paranoid (e.g. like everyone is out to get you)**
□ **Believe others can read your mind**
□ **Believe you can read others' minds**
□ **Believe others are trying to poison you**
□ **Hear voices or sounds others don't hear**
□ **See things others do not see**
□ **Engaged in any addictive behaviors (e.g., gambling, shopping, porn, internet, eating)**

**Please provide additional details regarding anything you checked off above (including age first started, when last experienced, how often experience, etc.)**

_____
_____
_____

**Please email or fax this form to my office. All information is kept in your CONFIDENTIAL medical record and will not be released without your consent.**