Empower Psychiatry & Sleep LLC.
BEHAVIORAL HEALTH QUESTIONNAIRE

Name_____ Age_____Date_____
MaritalStatus_____Occupation_____
Children_____ Who currently lives in your household?_____
_____

Who referred you here, or where did you hear about us? _____

Present History

Describe the reason for your visit today._____
_____
_____
_____

Are you currently depressed? Yes No
Have you had past episodes of depression? Yes No
Describe any **current** symptoms that you have regarding the following:
Sleep_____
Appetite_____
Mood/crying spells_____
Irritability/mood swings_____
Anxiety/Panic attacks_____
Energy/Motivation_____
Interest in normal activities_____
Guilt feelings_____
Libido_____
Concentration/Memory_____
Hearing Voices_____
Paranoia_____
Do you presently have suicidal thoughts? Yes No
Have you ever had suicidal thoughts? Yes No
Have you ever attempted suicide? Yes No
Do you or have you had homicidal thoughts? Yes No
Do you have any blood relatives who have committed suicide? Yes No
Please list the current stresses in your life: _____
_____
_____
_____
_____
_____

For Office Use Only:
Accompanied by: _____
HPI: _____

Please list your **current psychiatric** medications.
Medication_____Dose_____ How long?
Side effects_____
Medication_____Dose_____ How long? _____
Side effects_____
Medication_____Dose_____ How long? _____
Side effects_____
Medication_____Dose_____ How long? _____
Side effects_____

Past Psychiatric History

Prior Psychiatrists _____
Phone# _____
Past Therapists
_____
When/Why?
_____
Current Therapist
_____

For Office Use Only:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Have you ever been **hospitalized** in the past for any **psychiatric** reasons? Please list. Include Alcohol or Drug Treatments.

Date_____Place_____Reason_____
Date_____Place_____Reason_____
Date_____Place_____Reason_____

Please List all psychiatric medications that you have tried in the past. This includes any medications taken for your nerves, anxiety, depression or insomnia, such as Prozac, Paxil, ZoloV, Celexa, Lexapro, Effexor, Pristiq, Cymbalta, Wellbutrin, Buspar, Remeron, Trazodone, Elavil, Luvox, Xanax, Klonopin, Valium, Ativan, Risperdal, Zyprexa, Seroquel, Abilify, Geodon, Lithium, Depakote, Tegretol, Trileptal, Lamictal, Neurontin, Topamax, Ambien, Lunesta, Rozerem, Restoril, Adderall, Concerta, Ritalin, Focalin, Vyvanse, StraKera, Provigil, Namenda, Aricept.

Medication and Dosage	When/ How long?	Did it help?	Reason for stopping or side effects
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are you frequently nervous or anxious?	Yes	No
Are you a worrier?	Yes	No
Do you have panic attacks or hyperventilation?	Yes	No
Have you had panic attacks in the past?	Yes	No
Have you had a fear of objects or situations?	Yes	No
Do you do a lot of hand washing or going back and checking doors, stoves, lights, etc.?	Yes	No
Are you bothered by recurrent nightmares or flashbacks from a previous traumatic event?	Yes	No

How much alcohol do you drink? (quantitate)_____per_____

Are alcohol or drugs currently a problem?	Yes	No
Has alcohol or drugs ever been a problem?	Yes	No
Have you ever had a DUI or blackout?	Yes	No
Have loved ones been concerned about your alcohol/drug use?	Yes	No
Do you have any blood relatives with alcohol/drug problems?	Yes	No
Have you been arrested?	Yes	No
Have you had an eating disorder or caused yourself to vomit or lose weight?	Yes	No

Medical History

Please List any medical problems or diagnoses that you have?

_____
_____
_____
_____
_____

Any history of head trauma? Yes No
Any history of seizures? Yes No
Any history of developmental disorders? Yes No
Do you smoke? Yes No

If Yes, how much and for how long? _____

If quit, when? _____
Do you exercise regularly? Yes No

For women:
Do you still have regular periods? Yes No
Do you use birth control? Yes No
Are you taking any hormones? Yes No

Please give the name of your primary care doctor
Name_____
Address_____
_____
Phone# _____

For Office Use Only:

1. Const neg ___ pos ___
2. Eyes neg ___ pos ___
3. ENT neg ___ pos ___
4. Cardio neg ___ pos ___
5. Resp. neg ___ pos ___
6. GI neg ___ pos ___
7. GU neg ___ pos ___
8. Musc. neg ___ pos ___
9. Skin/Brest neg ___ pos ___
10. Neuro neg ___ pos ___
11. Endo neg ___ pos ___
12. Hem/Lymph neg ___ pos ___
13. Allergies neg ___ pos ___
14. Immune neg ___ pos ___

Please give the name of any other medical doctor from whom you receive regular treatment
Name_____Specialty_____
Name_____Specialty_____

Medical/Surgical Hospitalizations:
Date_____Reason_____
Date_____Reason_____
Date_____Reason_____
Date_____Reason_____

Please list all current medications:
Name_____ Dose_____ Reason taking _____
Name_____ Dose_____ Reason taking _____
Name_____ Dose_____ Reason taking _____
Name_____ Dose_____ Reason taking _____
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Name_____ Dose_____ Reason taking _____
Name_____ Dose_____ Reason taking _____
Name_____ Dose_____ Reason taking _____
Name_____ Dose_____ Reason taking _____

Are you allergic to any medications? Yes No
Medication_____ Reaction_____
Medication_____ Reaction_____
Medication_____ Reaction_____

Family/Social History

Who in your family has a psychiatric history?
Include history of alcohol or drug problem.
Relationship_____Problem_____
Relationship_____Problem_____
Relationship_____Problem_____
Relationship_____Problem_____

Social History:
Where were you born and raised? _____
Were you raised by your biological parents? Yes No
If no, describe_____
_____
_____
Do you have siblings? Yes No If so, how many? _____
Significant religious/cultural beliefs_____
Primary emotion sources of support _____
Have you ever been physically, emotionally, or sexually abused? Yes No

Please list any significant losses or deaths in your life:
Date_____Description_____
Date_____Description_____
Date_____Description_____
Date_____Description_____

Education _____
Work History_____
Are you currently married? Yes No If yes, how long? _____
Are you having marital or relationship problems? Yes No
If yes, describe_____
If you have children, do they have any significant psychiatric
or medical problems? Yes No
If Yes, please describe_____

Previous marriages? Yes No If yes, answer below.
When_____How Long_____
Reason for divorce/separation_____
When_____How Long_____
Reason for divorce/separation_____

SIGNATURE: _____**DATE**_____
Patient or Patient's Guardian