



Psychiatric Services of
Central New York

Creating Balanced LivingSM

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PATIENT HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

WE APPRECIATE ALL THE TIME AND TROUBLE YOU TAKE TO COMPLETE THIS QUESTIONNAIRE.
PLEASE ANSWER ALL QUESTIONS, WRITE "N/A" IF NOT APPLICABLE, AND DO NOT LEAVE BLANK SPACES.

Today's Date:			
PERSONAL INFORMATION:			
Name (Last, First, M.I.):		<input type="checkbox"/> M <input type="checkbox"/> F	DOB: AGE:
Legal Address:		P.O. Box	
City:	State:	Zip:	
Telephone please check box if it is ok for us to leave a message identifying ourselves, eg. "This is Dr. Farnum, calling for John Smith".			
<input type="checkbox"/> Home:		<input type="checkbox"/> Work:	
<input type="checkbox"/> Cell:			
Social Security Number:		(This information is used as a patient identifier only)	
Marital Status: <input type="checkbox"/> single <input type="checkbox"/> married <input type="checkbox"/> separated <input type="checkbox"/> divorced <input type="checkbox"/> domestic partnership <input type="checkbox"/>			
Who will be responsible for paying for your services here?			
Their relationship to you?			
Financially Responsible person's employer:			
Emergency Contact Name:		Phone:	
PLEASE FILL OUT A RELEASE OF INFORMATION FORM TODAY FOR THIS EMERGENCY CONTACT			
How did you hear about us?			
<input type="checkbox"/> phone book <input type="checkbox"/> my insurance company <input type="checkbox"/> my therapist <input type="checkbox"/> my doctor <input type="checkbox"/> word of mouth			
<input type="checkbox"/> other (please specify):			
YOUR CURRENT TREATMENT PROVIDERS			
Your current therapist or counselor	Name:		
Group:			
Address:			
Your current psychiatrist	Name:		
Group:			
Address:			
Your current medical doctor	Name:		
Group:			
Address:			

Psych medications, continued		PLEASE GIVE ALL INFORMATION YOU REMEMBER
MEDICATION & maximum dosage	HOW LONG	WHY YOU STOPPED TAKING THAT MEDICATION (side effects, didn't work, etc)

SUICIDAL AND PARASUICIDAL SYMPTOMS

Have you ever done something on purpose <i>with the intention</i> of killing yourself?	<input type="checkbox"/> yes <input type="checkbox"/> no
If YES, how many times and when?	
What method / methods did you use?	
Have you ever done anything to hurt or inflict pain on yourself (cutting, scratching, burning, etc) <i>without</i> the intention of killing yourself?	
<input type="checkbox"/> yes <input type="checkbox"/> no If YES, please explain.	
Do you CURRENTLY feel that you'd be better off dead, or that others would be better off if you were dead?	<input type="checkbox"/> yes <input type="checkbox"/> no
Have you been thinking about killing yourself recently?	<input type="checkbox"/> yes <input type="checkbox"/> no

GENERAL PSYCHIATRIC SYMPTOMS AND RELEVANT FACTS

Have you ever been physically abused?	<input type="checkbox"/> yes <input type="checkbox"/> no
Have you ever been sexually abused?	<input type="checkbox"/> yes <input type="checkbox"/> no
Have you experienced other severe trauma in the past?	<input type="checkbox"/> yes <input type="checkbox"/> no
Have you experienced missing blocks of time, even when not using alcohol or drugs?	<input type="checkbox"/> yes <input type="checkbox"/> no
Have you recently lost interest in things you normally enjoy?	<input type="checkbox"/> yes <input type="checkbox"/> no
Have you been feeling guilty without any real reason?	<input type="checkbox"/> yes <input type="checkbox"/> no
Have you recently been crying more than usual?	<input type="checkbox"/> yes <input type="checkbox"/> no
Have you recently had difficulty concentrating?	<input type="checkbox"/> yes <input type="checkbox"/> no
Have you recently had problems with your memory?	<input type="checkbox"/> yes <input type="checkbox"/> no
Does anxiety make it hard for you to do simple things most people do without a second thought?	<input type="checkbox"/> yes <input type="checkbox"/> no
Do you feel "stressed out" most of the time?	<input type="checkbox"/> yes <input type="checkbox"/> no
Do you feel anxious just talking to other people?	<input type="checkbox"/> yes <input type="checkbox"/> no
Do you have "panic attacks"?	<input type="checkbox"/> yes <input type="checkbox"/> no
Have you ever heard voices that other people don't hear?	<input type="checkbox"/> yes <input type="checkbox"/> no
Have you ever felt you had "special powers" that other people don't have?	<input type="checkbox"/> yes <input type="checkbox"/> no
Do you ever find you have boundless energy, so much that you don't need to sleep for days?	<input type="checkbox"/> yes <input type="checkbox"/> no
Are you often in such a good mood that people think there is something wrong with you?	<input type="checkbox"/> yes <input type="checkbox"/> no
Do you often feel compelled to do things repeatedly, such as counting or checking, even when you know there is no real reason to do so?	<input type="checkbox"/> yes <input type="checkbox"/> no
Are you disturbed by repetitive thoughts that you find offensive or bothersome?	<input type="checkbox"/> yes <input type="checkbox"/> no
Do you get "caught up" in certain patterns of thought or behavior that take up a lot of time, and interfere with your life?	<input type="checkbox"/> yes <input type="checkbox"/> no
Do you frequently "binge" on food, that is, eat to the point of discomfort?	<input type="checkbox"/> yes <input type="checkbox"/> no

Have you ever purged (made yourself throw up) after bingeing?	<input type="checkbox"/> yes <input type="checkbox"/> no
Do you hide food in your home so that you can secretly eat?	<input type="checkbox"/> yes <input type="checkbox"/> no
Have you used laxatives to get rid of food after bingeing?	<input type="checkbox"/> yes <input type="checkbox"/> no
Do you exercise excessively (over 1 hour a day) to lose weight? (does not apply to bodybuilders)	<input type="checkbox"/> yes <input type="checkbox"/> no
	<input type="checkbox"/> yes <input type="checkbox"/> no
	<input type="checkbox"/> yes <input type="checkbox"/> no
	<input type="checkbox"/> yes <input type="checkbox"/> no
	<input type="checkbox"/> yes <input type="checkbox"/> no
	<input type="checkbox"/> yes <input type="checkbox"/> no
	<input type="checkbox"/> yes <input type="checkbox"/> no

FAMILY PSYCHIATRIC HISTORY

Does anyone in your family (related to you by blood) have psychiatric problems? Please list even people who you think have problems, but have never received any diagnosis or treatment.

Relationship to you	Description of problem	Treatment (and did it work?)

SOCIAL HISTORY

Where were you born and raised?

Who were the "parent" figures in your home? Mother Father Stepmother Stepfather Other (list):

Kids in your home growing up: List by birth order, include yourself Check all that apply:

	<input type="checkbox"/> bro <input type="checkbox"/> sis	<input type="checkbox"/> half-sib	<input type="checkbox"/> step-sib
	<input type="checkbox"/> bro <input type="checkbox"/> sis	<input type="checkbox"/> half-sib	<input type="checkbox"/> step-sib
	<input type="checkbox"/> bro <input type="checkbox"/> sis	<input type="checkbox"/> half-sib	<input type="checkbox"/> step-sib
	<input type="checkbox"/> bro <input type="checkbox"/> sis	<input type="checkbox"/> half-sib	<input type="checkbox"/> step-sib
	<input type="checkbox"/> bro <input type="checkbox"/> sis	<input type="checkbox"/> half-sib	<input type="checkbox"/> step-sib
	<input type="checkbox"/> bro <input type="checkbox"/> sis	<input type="checkbox"/> half-sib	<input type="checkbox"/> step-sib
	<input type="checkbox"/> bro <input type="checkbox"/> sis	<input type="checkbox"/> half-sib	<input type="checkbox"/> step-sib

Is there anything else I should know about your situation growing up?

MARRIAGE AND CHILDREN

Please tell us about your marriages (legal and common-law), significant relationships and children:

(example given)

Years	status	children	Age now	
1990-98	Divorced	<input checked="" type="checkbox"/> male <input type="checkbox"/> female <input checked="" type="checkbox"/> step <input type="checkbox"/> adopted	23	From 1 st marriage, lives in California, no contact.
		<input type="checkbox"/> male <input type="checkbox"/> female <input type="checkbox"/> step <input type="checkbox"/> adopted		
		<input type="checkbox"/> male <input type="checkbox"/> female <input type="checkbox"/> step <input type="checkbox"/> adopted		
		<input type="checkbox"/> male <input type="checkbox"/> female <input type="checkbox"/> step <input type="checkbox"/> adopted		
		<input type="checkbox"/> male <input type="checkbox"/> female <input type="checkbox"/> step <input type="checkbox"/> adopted		
		<input type="checkbox"/> male <input type="checkbox"/> female <input type="checkbox"/> step <input type="checkbox"/> adopted		
		<input type="checkbox"/> male <input type="checkbox"/> female <input type="checkbox"/> step <input type="checkbox"/> adopted		

EDUCATION

High School

Name of school:	Highest grade completed:
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College	Years completed	Major	Degree
Name of College/University:			
Name of College/University:			
Name of College/University:			
Name of College/University:			

LEGAL HISTORY

Have you ever been arrested? <input type="checkbox"/> yes <input type="checkbox"/> no	Have you ever been convicted of a crime? <input type="checkbox"/> yes <input type="checkbox"/> no
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SUBSTANCE USE HISTORY

Alcohol:	Do you drink alcohol?		<input type="checkbox"/> yes <input type="checkbox"/> no	
	If yes, how many drinks per day, or per week?			
	At what age did you begin drinking?			
	Are you concerned about the amount you drink?		<input type="checkbox"/> yes <input type="checkbox"/> no	
	Is anyone else concerned about the amount you drink?		<input type="checkbox"/> yes <input type="checkbox"/> no	
	Have you considered stopping?		<input type="checkbox"/> yes <input type="checkbox"/> no	
	Have you experienced blackouts?		<input type="checkbox"/> yes <input type="checkbox"/> no	
	Have you experienced alcohol withdrawal?		<input type="checkbox"/> yes <input type="checkbox"/> no	
	Are you prone to "binge" drinking?		<input type="checkbox"/> yes <input type="checkbox"/> no	
	Do you drive after drinking?		<input type="checkbox"/> yes <input type="checkbox"/> no	
	If you are in recovery, how long have you abstained from alcohol (been alcohol-free)?			
	If you are in recovery, do you "work a program" or attend AA?		<input type="checkbox"/> yes <input type="checkbox"/> no	
	How many meetings a week do you attend?			
	Tobacco:	Do you use tobacco?		<input type="checkbox"/> yes <input type="checkbox"/> no
Cigarettes (packs per day)		Chew (how many per day)	Pipe (how many per day)	
How many years?		Or year quit:		
Drugs:	Do you now, or have you ever used recreational or street drugs? (please describe below)		<input type="checkbox"/> yes <input type="checkbox"/> no	
	Now:			
	Past:			
	Have you ever given yourself street drugs with a needle?		<input type="checkbox"/> yes <input type="checkbox"/> no	
	If you are in recovery, how long have you been drug-free?			
	If you are in recovery, do you "work a program" or attend NA?		<input type="checkbox"/> yes <input type="checkbox"/> no	
	How many meetings a week do you attend?			
Have you ever been to Detox? Please state when and where, and for what substance.			<input type="checkbox"/> yes <input type="checkbox"/> no	
Have you ever been to Rehab? Please state when and where, and for what substance.			<input type="checkbox"/> yes <input type="checkbox"/> no	
Have you ever been to a mandated Chemical Dependency program? Please state when and where.			<input type="checkbox"/> yes <input type="checkbox"/> no	
Have you ever gotten a DUI?			<input type="checkbox"/> yes <input type="checkbox"/> no	

EMPLOYMENT HISTORY

Current Employer:

How long?

What do you do at your job?

What other kinds of work have you done?

What was your longest employment at the same job?

What was your longest period of unemployment?

YOUR INSURANCE COVERAGE

Insurance Company:

Policy#:

Plan:

1.

2.

3.

Date:

Signature:

Thank you for your time and patience in completing this Questionnaire!