16 Junction Drive West, Suite 2, Glen Carbon, Illinois 62034 Phone: 618- 288-5019 Fax: 618-288-5059

SOUTHERN ILLINOIS ASSOCIATES, LLC

PSYCHIATRIC EVALUATION QUESTIONNAIRE

IDENTIFYING DATA **Date**:______________________

Name: ____ **Age**:_____**Yrs**. **Date of Birth**: ___________________

Address: ____

Sex: Male / Female **Race**: White / Black / Asian / Other: ____________________________________

Marital Status: Married / Single / Divorced / Widowed / Separated / Other: ______________________________

Who else lives with you?____

What is the reason for today's visit?____

____

____

____

____

____

PREVIOUS HISTORY OF PSYCHIATRIC TREATMENT

Outpatient: Yes / No How Long ________________ When __________ Where ________________

Treating Psychiatrist or Therapist: ____

Have you ever been admitted to psychiatric hospital? Yes / No How many times _________________________

When was your last admission? __________. Why were you admitted?_______________ Diagnosis? __________ Where?

Have you ever received ECT treatment: ______________?

Have you ever attempted suicide?_________________________

MEDICAL HISTORY Circle all which apply

Measles / Mumps / Chicken Pox / Whooping Cough / Asthma / Seizures / Others: ___________________________

Any other diseases like; Diabetes, High Blood Pressure, Heart Attacks, Sexually Transmitted Diseases, HIV (AIDS), hepatitis, Ch. Fatigue syndrome, Fibromyalgia, Others: ____

Surgical History: Tonsillectomy / Appendectomy / Gallbladder / Hernia / Hysterectomy / and Other: _________________

History of serious injuries: Yes / No Describe____

Head Injury: Yes / No **Seizure Disorder**: Yes / No ____

ALCOHOL/DRUG HISTORY

Smoking: Yes / No How many packs per day ____________________ for how many years_________________________

What is your drinking pattern? Regular, Social, Binge, ____

How much beer, whiskey, vodka or other, and how often? ____

Have you use or abuse Marijuana / Cocaine / Crack / Heroin / Crystal Meth / Stimulants / Pain Pills / Others ____

History of previous treatment for substance abuse: Yes / No. If Yes, When, where, and for how long?_______

Do you have problems with the law? ___Yes ___No.

Any family history of psychiatric illness:

Yes Than Explain:____

Anyone in the family has problem with alcohol or street drugs? Yes / No If yes, please explain:____________________

Any family history of medical illness? Yes / No Explain____

Any other comments of importance about your family____

____

Any family history of suicide or suicidal attempt? ____

PERSONAL HISTORY

Birth: Normal / Cesarean Sections / Breech / Premature / Other____

Developmental Milestones: Normal / Delayed

Nervous Habits: Nail Biting / Thumb Sucking / Bed Wetting / Other:____

Did You Have A Happy Childhood? Yes / No, Explain:____

Any other comments of importance about your history:____

____

Education: Highest Grade Completed____________________________ GED____

Type of Student: Above Average / Average / Below Average

Any Difficulties in School: _______________ Behavioral: ______________ Learning Disabilities: ___________________

Any Time Disciplined In School:____

Secondary Education: College / Junior College / Technical / Trade / Other: ____

Current Employment History: Employed / Unemployed / How Long:____

Employer _________________________ Occupation____

Previous Job: ____

Military Service: Yes / No / Type of discharge:____

Financial Support: Job / Pension / SSI / Public Aid / Child Support / Alimony / Unemployment / Other_______

Hobbies and Interests:____

MARITAL HISTORY

Married _____ Divorced/Separated _____ how many times married _____ Reason for divorce _______________________

____

Do you have any children? Yes / No How Many? Sons ________ Daughters _______ Adopted _______

Do they live with you? Yes / No Please Explain:____

Menstrual History (Females): Regular / Irregular / Menopausal / Hormone Supplements / Others ______ LMP _________

Did you (Female) experience any mood changes after the birth of your children? Yes / No Explain____________________

Any history of Traumatic experiences: Emotional / Physical / Sexual / Please explain:____________________________

____

Have you been treated for it? Yes / No If yes, Where __________________ When _________________________________

Are you currently taking medications? Yes / No If yes, please name the medication and dosage:

Allergies: ____

Name and address of your private physician:____

____