Behavioral Healthcare Corporation
Mental health for all we serve.™

Outpatient Psychiatric Clinic
Information Questionnaire

Name : _____ Preferred Name: _____

Street: _____ City/State/Zip: _____

Phone : _____ Gender (circle): M F

Birth Date : _____ Age : _____ Social Security #: _____

PERSON TO BE NOTIFIED IN CASE OF AN EMERGENCY:

Name: _____ Phone: _____

When was the last time things were going well? _____

For how long? _____

PROBLEM HISTORY:

How would you describe the reason you are seeking services? _____

_____

_____

Have you ever received care before for your problems? Y_____ N _____

How long did you receive, or have you been receiving, care? _____

Where have you received clinical services?

Date:	Length of Treatment:	Agency / Hospital	Type of Clinical Service:

Please list any changes you have noticed recently in your:

Sleeping habits: _____ How many hours/night? _____ Energy level: _____

Eating habits: _____ Appetite? _____ Activity level: _____

Sexual interest: _____ Sexual concerns? _____ Thoughts? _____

What have you found yourself being concerned with recently? _____

_____

What would you like to accomplish in this program and how would you know if things were better for you? _____

_____

Do you have an Advanced Directive and/or a Wellness Recovery Action Plan (WRAP)? Y_____ N_____

822 Marietta Avenue Lancaster, PA 17603
535 Locust Street Columbia, PA 17512
717.399.8288 (P) 717.399.8968 (F)

Name: _____ ID#: _____

MEDICAL HISTORY:

Please list any medical conditions we should know about _____

Who is your doctor or primary care practitioner? _____

Do you have any known allergies or drug sensitivities? _____

Current medications and dosage: _____ _____

_____ _____ _____

SUBSTANCE ABUSE HISTORY:

How often do you drink and how much do you usually drink each time? _____

Do you use any drugs not prescribed by your doctor? _____

If so, what, how often and how much? _____ _____ _____

Do you ever take more medication than your doctor has prescribed? Y _____ N _____

Have alcohol or drugs ever been a problem for you? _____

Do you smoke or use other forms of tobacco? If so how often and how much? _____

FAMILY SYSTEM REVIEW

Maiden Name/Other names by which you've been known:

_____

Mother's name: _____ Address: _____ Phone: _____

Father's name: _____ Address: _____ Phone: _____

Siblings (List in order of age, including yourself)

Name (Brother, Sister)	Age

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Name: _____ ID#: _____

Significant Other/Spouse_____

Address: _____ Phone: _____

CHILDREN:

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Do your children live with you? Y _____ N _____ If not, where do they live? _____

What was it like growing up in your family? _____

Who are you close to now? _____

Are you estranged from anyone? Y _____ N _____ If so, why? _____

_____

Have you ever been emotionally, physically or sexually abused? Y _____ N _____

Has anyone in your family ever received care for an emotional problem? Y _____ N _____

Relationship: _____ Problem: _____

Has anyone in your family ever committed suicide? Y _____ N _____

SOCIAL AND ENVIRONMENTAL REVIEW

Who do you live with now? _____

How long have you lived there? _____

Are you currently having any problems with your living arrangements? _____

What are your current financial responsibilities? _____

_____

When you were at your best, how did you spend your leisure time? _____

_____

How do you currently spend your leisure time? _____

_____

What do you consider your greatest strengths and/or like about yourself? _____

_____

How do you think other people would describe you? _____

_____

_____

Name: _____ ID#: _____

EDUCATION REVIEW

What was the highest grade you completed in school? _____

What problems, if any, did you have in school? _____

What did you like best about school? _____

Do you plan to further your education? _____

EMPLOYMENT HISTORY

Current place of employment: _____ How long? _____

Type of work: _____

Past place of employment: _____ Year: _____ How long? _____

Do you have any goals to find new employment? _____

Have you ever had work-related problems in the past? _____

If so, what type of problems did you have? _____

MILITARY HISTORY

Branch: _____ Dates of service: _____

Type of discharge: _____

LEGAL HISTORY

Have you ever had legal problems? Y _____ N _____ Please describe: _____

_____

Have you ever been detained for any reason? _____

Have you ever served a sentence? Y _____ N _____ Please describe: _____

_____

Name of probation/parole officer: _____

Is there anything else our staff should know about you at this time? _____

_____

_____

_____

_____

_____

_____

_____

_____

Signature: _____ Date: _____