Beautiful Minds
Dr. Humera Chowdhary MD
Beautiful Minds for Beautiful Lives

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Humara Chowdhary MD
Medical Director

Therapist: _____ Date: _____

QUESTIONNAIRE FOR NEW PATIENTS

Please complete as fully as possible. If you need additional space, please use the back of the page.

Name	Date of Birth	Age	Sex
Address	City	State	Zip
Phone	Phone or Email		
Referred By	Phone		
Address	City	State	Zip

Please state the reason you are coming for psychiatric evaluation. What is the problem(s)?

When and how did the problem(s) begin?

What has been done so far to try to alleviate the problem(s)?

What help do you want at this time?

Psychiatric History

Have you received any previous outpatient psychiatric treatment counseling, or have you taken any medication for the treatment of any psychiatric or emotional problems (including sleeping pills)?

❑ No ❑ Yes If Yes, please specify:

Most recent dates of counseling: _____ to _____

Name of therapist _____

Was treatment helpful? ❑ Yes ❑ No

Dates of medication: _____ to _____

Name of medication _____ Dosage _____

Was treatment helpful? ❑ Yes ❑ No

Please list all past psychiatric and psychological treatment:

Have you ever been hospitalized for psychiatric treatment?

❑ No ❑ Yes If Yes, please specify:

Dates of hospitalization: _____ to _____

Name of hospital _____

Reason for hospitalization _____

Was hospital treatment helpful? ❑ Yes ❑ No

Dates of hospitalization: _____ to _____

Name of hospital _____

Reason for hospitalization _____

Was hospital treatment helpful? ❑ Yes ❑ No

Medical History

Have you suffered from any of the following medical problems:

- ❑ Head injuries (concussions, loss of consciousness)
- ❑ Seizures
- ❑ Recurrent headaches
- ❑ Allergic reactions to medications
- ❑ Other allergies
- ❑ Asthma
- ❑ Glaucoma
- ❑ Heart disease
- ❑ Hearing impairment
- ❑ Kidney problems
- ❑ Diabetes
- ❑ Hormonal problems
- ❑ Liver problems
- ❑ Hospitalization for medical illness
- ❑ Surgery
- ❑ Other medical problems (describe)

If any of the above are checked, please provide details:

Are you currently taking any medications?
(Include over-the-counter medicine, such as cold, allergy or sleeping pills.)

Name of medication_____ Dosage _____ Taken since _____

Name of medication_____ Dosage _____ Taken since _____

Name of medication_____ Dosage _____ Taken since _____

Name of medication_____ Dosage _____ Taken since _____

Date of your last physical examination _____

Name of your personal physician _____

Address _____

Phone _____

Sleep Difficulties? ❑ No ❑ Yes If Yes, explain:

Appetite Difficulties? ❑ No ❑ Yes If Yes, explain:

Do you smoke cigarettes? ❑ No ❑ Yes If Yes, how many daily _____ For how many years _____

Do you drink alcohol? ❑ No ❑ Yes

If Yes, how many drinks per week _____

Have you or anyone close to you ever thought you had a drinking problem? ❑ No ❑ Yes

Do you use recreational drugs? ❑ No ❑ Yes

Living Environment

Marital Status ❑ Married ❑ Single

Others in household

Spouse _____ Age _____

Children

Name _____ Age _____ ❑ Male ❑ Female

Name _____ Age _____ ❑ Male ❑ Female

Name _____ Age _____ ❑ Male ❑ Female

Name _____ Age _____ ❑ Male ❑ Female

Others

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Your Occupation _____

Spouse's Occupation _____

Do any family/household members currently suffer from significant physical health problems? ❑ No ❑ Yes:

Do any family/household members currently suffer from significant mental / emotional health problems?
❑ No ❑ Yes:

Education

Your educational attainment (check highest level obtained):

❑ Did not graduate high school
❑ High school graduate
❑ Some college
❑ College graduate
❑ Advanced college degree

Describe your social and academic adjustment

Elementary School

Junior High School

High School

Life Events

Significant or painful experiences in life, including death of meaningful people, separation from family, absence or major illness of parent or sibling, moves:
Relationship with siblings
Description of your family of origin (who was in the family, economic status, current relationship, significant problems or issues):
Past events or situations which you feel have been important in your life:
How would you characterize your current life: Marriage Family Life Job Health Other significant factors, including how your problems have impacted on you:

Family History

Have any of your biological relatives had the following problems?

	Father	Mother	Siblings	Offspring	Other Family (specify
Depression					
Anxiety Problems					
Obsessive-Compulsive Disorder					
Bipolar Mood Disorder					
Alcohol Abuse					
Schizophrenia					
Hospitalized for Psychiatric Reasons					
Learning Difficulties as a Child					
Hyperactivity					
Mental Retardation					
Other Psychiatric Problems					
Criminal Behavior					
Unknown					

Please provide any other information that you believe might be helpful to us in understanding the problem(s) you have been having.