Barrington Behavioral Health Services, LLC

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Patient Questionnaire

Name:_____ Today's Date:_____

Address:_____

Home Phone:_____ Work Phone:_____

Cell Phone: _____ Email:_____

Sex:_____ Religion:_____ Date of Birth:_____ Age:_____

Are you currently ( ) married ( ) widowed ( ) divorced
( ) separated ( ) have never been married?

With whom do you live:_____

_____

Previous Marriages (if any)_____

_____

Your Family of Origin:

Family Members	Age	Health	Education/Work
Father _____	___	_____	_____
Mother _____	___	_____	_____
Siblings			
_____	___	_____	_____
_____	___	_____	_____
_____	___	_____	_____
_____	___	_____	_____
_____	___	_____	_____
_____	___	_____	_____

In what kind of home do you live? ( ) private ( ) duplex
( ) apartment building ( ) other_____
Is the dwelling ( ) owned or ( ) rented?

MEDICAL HISTORY
Have you been diagnosed with any behavioral, educational, medical, neurological, or psychiatric disorder, such as Attention Deficit Hyperactivity Disorder (ADHD), Learning Disorder (LD), or Anxiety and Mood Disorders? Yes No If *Yes*, please specify:_____
_____
_____
Do you have any *current* medical conditions? Yes No If *Yes*, please list.
_____

Do you have any *chronic or recurrent* medical conditions? Yes No If *Yes*, please list.

_____
Any experience of abuse or trauma?_____
_____

PREVIOUS ILLNESSES:
Place a check next to any illness or condition that you have had.

Illness or Condition Illness or Condition Illness or Condition
___ Anemia ___ Epilepsy or seizures ___ Loss of consciousness
___ Arthritis (juvenile) ___ Fainting ___ Malnutrition
___ Bleeding problems ___ Fatigue (if chronic and severe) ___ Measles
___ Bone or joint disease ___ Hay fever ___ German measles
___ Broken bones ___ Head injury ___ Meningitis ___ Tuberculosis
___ Cancer ___ Headaches (frequent or severe) ___ Mumps
___ Chicken pox ___ Heart disease ___ Paralysis
___ Diabetes ___ Hepatitis ___ Rheumatic fever
___ Diphtheria ___ High blood pressure (hypertension) ___ Scarlet fever
___ Eczema or hives ___ High fever (greater than 104 degrees)
___ Encephalitis ___ Jaundice ___ Whooping cough

VISION: Date of most recent vision exam _____
Do you have any vision problems ? Yes No If *Yes*, is your vision corrected with (circle one): Eyeglasses Contact lenses Surgery

HEARING: Date of most recent hearing exam _____
Do you have any hearing problems ? Yes No If *Yes*, has your hearing been treated? _____

ALLERGIES:_____
_____

MEDICAL TREATMENT: Date of most recent medical exam _____
Physician's name:_____
Address _____
Phone: _____

If you have ever undergone an operation or hospitalization, please list the problem below (usually an illness), your age, and the medical procedures that were implemented during the hospitalization.

Problem	Age	Procedure
_____	____	_____
_____	____	_____
_____	____	_____
_____	____	_____
_____	____	_____
_____	____	_____

If you have ever been treated with prescription medication other than for colds and minor infections, please list them below:

Medication	Age	Reason Prescribed
Current		
_____	____	_____
_____	____	_____
_____	____	_____
_____	____	_____
_____	____	_____

How often do you use alcohol, and what do you typically drink?
_____

List any recreation drugs you use and how often you use them.

_____
_____

Have you used more alcohol or drugs than you intended this year? Yes No
Have you ever felt the need to cut down on the amount you drink or use drugs? Yes No
Do you smoke cigarettes? yes no If so, how frequently?_____
Have you been diagnosed with any behavioral, educational, medical, neurological, or psychiatric disorder, such as Attention Deficit Hyperactivity Disorder (ADHD), Learning Disorder (LD), or Anxiety and Mood Disorders? Yes No If *Yes*, please specify: _____

_____
_____

Do you have any *current* medical conditions? Yes No If *Yes*, please list.

_____
_____

Do you have any *chronic or recurrent* medical conditions? Yes No If *Yes*, please list.

_____
_____
_____

Developmental History
Were there any complications with your pregnancy or birth? yes no

_____

Childhood illnesses and accidents:

_____
_____

Were you adopted? yes no If yes, when?_____
Did you live anyone other than your parents while growing up? yes no

_____

FAMILY MEDICAL HISTORY
Have any other family members shown similar problems or challenges? Yes No
If *Yes*, who?

_____
_____

Place a check next to any illness or condition that any member of the family has had. When you check an item, please note the FAMILY member's relationship to you.

Relationship

____ ADHD or Hyperactivity _____
____ High Blood Pressure _____
____ Anxiety or Worry Problem _____
____ Huntington's Chorea _____
____ Depression _____
____ Kidney Disease _____
____ Learning problems _____
____ Mental Retardation _____
____ Manic-Depressive Disorder _____
____ Migraine Headaches _____
____ Reading Problem _____

____ Muscular Dystrophy _____
____ Speech or Language Problem _____
____ Multiple Sclerosis _____
____ Sexual/physical abuse _____
____ Nervous Breakdown or Problems _____
____ Parkinson's Disease _____
____ Alcoholism _____
____ Physical Handicap or Disability _____
____ Alzheimer's Disease _____
____ Seizures or Epilepsy _____
____ Birth Defect _____
____ Sickle Cell Anemia _____
____ Cancer _____
____ Stroke _____
____ Cerebral Palsy _____
____ Suicide attempt _____
____ Cystic Fibrosis _____
____ Tay-Sachs Disease _____
____ Diabetes _____
____ Tourette's Syndrome or Tic Disorder _____
____ Drug Addiction or Dependency _____
____ Tuberculosis _____
____ Heart Disease or Heart Attack_____
____ Hemophilia _____
____ Other_____

Anything else we should know about your health and medical care?

_____
_____
_____
_____
_____
_____
_____

Educational History

Please list schools you have attended:

School Dates Special Achievements (Degrees)/Problems (if any)

1._____

2._____

3._____

4._____

Please list your work history (Current to oldest):

Job Dates Special Achievement/Problems (if any)

1._____

2._____

3._____

4._____

Additional Comments:_____

_____

_____

Entrance Complaint

For what reasons are you seeking help?_____

_____

_____

What thoughts do you have regarding the possible causes of your issues?

_____

_____

_____

_____

Is there anything else that I should know?_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____