# PSYCHIATRIC DISORDERS QUESTIONNAIRE

**To be completed by the treating physician**
**(PLEASE USE BLOCK LETTERS)**

## 1. PATIENT'S INFORMATION

| | | | |
|---|---|---|---|
| Name | Last | First | M.I. |
| Date of birth | MM / DD / YYYY | | |

## 2. MEDICAL INFORMATION

Diagnosis (PLEASE MARK ALL THAT APPLY)

| | | |
|---|---|---|
| ☐ Generalized anxiety | ☐ Obsessive-compulsive disorder | ☐ Panic syndrome |
| ☐ Mild or moderate depression | ☐ Bipolar disorder | ☐ Schizophrenia |
| ☐ Major depression | ☐ ADHD / ADD | ☐ Other |

Please describe patient's symptoms, how often they occur, severity, and current status:

| | |
|---|---|
| Date of first symptom | |
| MM / DD / YYYY | |
| Date of last symptom | |
| MM / DD / YYYY | |

Is or was the patient taking any medication for this condition? ☐ Yes ☐ No If "Yes", please provide name of medication, dosage and frequency of use.

| | |
|---|---|
| Start date | |
| MM / DD / YYYY | |
| Stop date | |
| MM / DD / YYYY | |

Does the patient visit a doctor/psychiatrist for this condition? ☐ Yes ☐ No If "Yes", please indicate frequency.

Has the patient received counseling or therapy for this condition? ☐ Yes ☐ No If "Yes", please indicate frequency and date of last session.

| | | |
|---|---|---|
| | Date | MM / DD / YYYY |

What other treatments has the patient received for this condition? (PLEASE MARK ALL THAT APPLY)

| Date | Treatment |
|---|---|
| MM / DD / YYYY | ☐ Emergency room visit(s) |
| MM / DD / YYYY | ☐ Hospitalization |
| MM / DD / YYYY | ☐ In-patient treatment |
| MM / DD / YYYY | ☐ Other |

Has the patient ever had any suicidal ideation or any suicide attempts? If "Yes", please provide date. ☐ Yes ☐ No

| | | |
|---|---|---|
| Date | MM / DD / YYYY | |

| Is there any additional information that has not been mentioned before? ☐ Yes ☐ No If "Yes", please provide details. |
|---|
| |

## 3. TREATING PHYSICIAN'S INFORMATION

| | | | |
|---|---|---|---|
| Name of physician | | | |
| Address | | | |
| Telephone | | Fax | |
| Email | | | |
| Signature | | Date | MM / DD / YYYY |

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