William K. Drell M.D.
902 Frostwood
Suite 283
Houston, Texas 77024

Patients Name _____
Nickname_____
Age _____ **Sex: M**____**F**_____**Other**___
Self Identified Race _____
Date _____

New Patient Psychiatric Questionnaire

Chief Complaint

1. Please list the reasons you have sought a psychiatric consultation at this time?

_____
_____
_____
_____

For Doctor's Use Only:

_____
_____
_____
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_____

2. Sleep: My sleep is normal—yes/no. (If not normal, circle problem)
I have trouble: falling asleep; Staying asleep; waking up too early; or sleeping too much.

3. Energy: (circle one) My energy is normal; too low; too high.

4. Appetite: (circle one) My appetite is normal; decreased; increased; have you lost or gained weight recently? If so, how much?

_____

5. Have you ever become desperate enough to consider:
Death? (Y) (N) Hurting yourself? (Y) (N) Suicide? (Y) (N)
Hurting someone? (Y) (N) Homicide? (Y) (N) Divorce? (Y) (N)
Destroying something? (Y) (N) Running away? (Y) (N)
Doing something crazy? (Y) (N) Using Drugs? (Y) (N)

6. How were you referred to Dr. Drell? _____
7. May we thank and/or share information with you referral source? Yes No
if Yes, please place your initials here _____

_____
Past Psychiatric History

8. Have you seen any other psychiatrists or therapists prior to this appointment?
Yes No

If yes, please list their names and addresses, and whether or not give us permission to request information and records from the physician/therapist if necessary.

Name/address each clinician) Dates of treatment Permission to obtain from or release (of information to each clinician listed
Yes No Initial here _____

_____
_____
_____
_____
_____

9. Have you ever been hospitalized for psychiatric problems, alcohol, or substance abuse? If so, please fill out the following?

Hospital _____
Dates_____
Hospital_____
Dates_____
Hospital_____
Dates_____

10. Have you taken any psychiatric medications in the past? These might include the following: Elavil, Doxepin, Pamelor, imipramine, Prozac, Zoloft, Paxil, Lexapro, Celexa, Luvox, Serzone, Ativan, Klonopin, Librium, Haldol, Navane, Thorazine, Mellaril, Zyprexa, Risperadal, Seroquel, Geodon, Abilify, Lamictal, Tegretol, Topamax, Depakote, etc. if so, please list them below.

Medication Dosage instructions Reason You Stopped it
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Medical History

11. Who is your primary medical doctor? _____
Address _____ Date last seen _____

Do you give permission for us to discuss your case with your primary medical doctor if clinically necessary? Yes No initial here please _____

12. Do you have any current health problems? Please list:

_____
_____
_____

13. Please write your height _____ weight _____ideal weight _____

Waist size in inches (as a baseline for medication related weight change) _____

14. Do you have a family history of Diabetes, Heart Disease, sudden death, prolonged QT Syndrome, Cardiomyopathy, thyroid problems, ETC. ?

_____
_____
_____
_____

15. Are you currently on any medications? Yes No
If yes, please list them below:

Medication Dosage Directions

_____
_____
_____
_____
_____
_____
_____
_____
_____

16. Are you taking any vitamins, herbal products, dietary supplements, alternative medications or weight loss preparations? Please list them below:

_____
_____
_____
_____

17. Are you allergic to any medications? If yes, please list:

_____
_____

18. Have you had any surgeries in the past? If so, please list the type of surgery and date:

_____
_____
_____
_____

19. Do you suffer from chest pain, shortness of breath, palpitations, or dizziness on exertion? Yes _____ No_____

20. Have you ever fainted or almost fainted (especially without exercising)? Yes _____ No_____

21. Gave you had any head injuries, loss of consciousness or seizure disorders? Yes _____ No _____

22. Do you have tics, facial twitches, or tremors? Yes _____ No _____
Do you have a family history of these? Yes _____ No _____

23. Do you have a history of glaucoma? Yes _____ No _____ Is it being treated? _____

24. Do you have a pacemaker, implantable pumps or metal appliances? YES_____ No_____

25. Do you obsess on food, overeat compulsively, restrict what you eat, or vomit (purge) intentionally? Yes _____ No _____

26. Are you pregnant or do you plan to get pregnant soon? _____
When was your last menstrual period? _____

Family Psychiatric History

27. Has anyone in your family had emotional or psychiatric problems, drug/ alcohol abuse problems, or suicide? (include grandparents, aunts, uncles, parents, siblings, child- ren or spouse).
Please list and explain what problems and treatments they have received.

Relative/age emotional problems	Specific drug/alcohol or received	Treatment received

_____
_____
_____
_____
_____
_____
_____

Social History

28. Please list the name and age of your parents, spouse, children, siblings, and significant other, as well as their occupations.

Name	Age	Occupation/Cause Of Death

Mother
_____
Father_____
Siblings_____
_____
Spouse/significant other_____
Chlidren_____
_____
_____
_____

29. Did your parents ever divorce or separate? Yes _____ No _____
If yes, how old were you? _____ Who did you live with? _____

30. Where were you born and raised? _____

31. Have you been a victim of physical, sexual, or emotional Abuse? Yes_____ No _____
If so, by whom? _____
Has anyone at home hit or harmed you? Yes _____ No _____
Do you feel safe at home? Yes _____ No _____

32. Were either of your parents sexually or physically abused or did your mother suffer from ptsd (post traumatic stress disorder)?
Yes _____ No _____

33. Have there been any significant stressors in the last 12 months (debt, divorce, illness, moves, etc.)?
_____
_____
_____

34. Who currently lives in your household?
_____
_____
_____

35. Do you consider yourself Heterosexual _____ Homosexual _____ Bi - sexual_____
36. How many times have you been:
Married? _____ _Divorced? _____Separated? _____Widowed? _____

37. What was your longest marriage?_____

38. When were you growing up, did you have a normal development (walk on time/talk on time, etc.)?

_____

39, What is your highest educational level of completed education?_____
40. Where do you work or go to school?

_____
_____

41. How long have you been at your current job?_____

42. How long was your longest job?_____

43. Were you in the military? _____ If so, when and which branch?

_____

44. Do you currently have any stressors related to finances?

_____
_____

45. Do you have any legal problems?

_____

46. What is your religious preference?_____
Are you actively involved? _____

47. What are your hobbies? What do you do for FUN?_____

_____
_____

48. Drug/Alcohol and Tobacco History_____

Substance	Amount	Frequency	Duration	1st use	Last use
Caffeine					
Tobacco					
Alcohol					
Marijuana					
Opiates /narcotics					
Amphetamines					
Cocaine					
Hallucinogens					
Synthetic drugs/bath salts/incense					
OTHERS					

49. _____ Yes _____ No do you drink alcohol in the morning?

_____ Yes _____ No Have you ever had a DWI or public intoxication charge?
_____ Yes _____ No Do you feel you are a normal drinker or non drinker currently?
_____ Yes _____ No Was there a time in the past when you felt you used alcohol or drugs excessively?
____Yes _____No Do friends/relatives think you're a normal drinker or non-drinker?
_____ Yes _____No Have you ever lost friends or girl/boyfriends because of your drinking?
_____ Yes _____No have you ever gotten into trouble at work because of drinking?
_____ Yes _____No Have you ever neglected your obligations, family, or your work for 2 or more days in a row because of your drinking?
_____ Yes _____No Have you ever had delirium tremens (DTs), severe shaking, hearing voices, or seen things that weren't there after heavy drinking?
____ _ Yes _____ No Have you ever gone to anyone for help for your drinking or drug usage?
____ _ Yes _____No Have you ever been in a hospital because of drinking or drug usage?
____ _ Yes _____No Have family or friends ever expressed concern over your use of drugs?
____ _ Yes _____No Have you ever been arrested for any offense involving drugs?
_____ Yes _____No Have you ever been treated for chemical dependency?
_____Yes _____No Have you overdosed on drugs (accidentally or on purpose) ?
_____Yes _____No hHve you ever attended a 12 step meeting (AA, NA CA, ALANON, etc.) IF yes, which ones? _____

50.
A. Do you often have trouble wrapping up the final details of a project once the challenging part is done? Yes _____No _____

B. Do you often have difficulty getting things in order when you have to do a task that requires organization?
Yes _____No _____

C. Do you often have problems remembering appointments or obligations? Yes _____No _____

** Please don't forget our 24 hour cancellation policy **

D. Do you often procrastinate getting started when a task requires a lot of thought? Yes _____No_____

E. Do you often feel restless with your hands or feet when you have to sit down for a long time? Yes _____No _____

F. Do you often feel restless or overly active and compelled to do things like you were driven by a motor? Yes _____No _____

Miscellaneous

51. Do you have any intrusive, unwanted or repetitive thoughts that you cannot control (obsessions)? Yes _____ No _____

52. Do you wash your hands excessively or repeatedly check things (compulsive behaviors)? Yes _____ No _____

53. Do you do needless counting or repeating? Yes _____ No _____

54. Do you have a history of: (please circle) Promiscuity? Compulsive spending? Reckless driving? Gambling?

55. Do you own a handgun? Yes _____No _____
When did you purchase/obtain it?_____

56. Do you agree with the following statements?
Suicide is a normal behavior. Yes_____ No_____
Sometimes suicide is the only escape from life's problems. Yes_____No_____
In general, suicide is an evil act not to be condoned. Yes_____No_____
I have a religious/moral prohibition of suicide. Yes____No_____

57. Please list your strengths (E.G. positive personality traits, talents, what is good about you?):

_____
_____

58. Please list your weaknesses or limitations:

_____
_____

59. Please list any personal changes you would like to make:

_____
_____
_____

_____
Signature/Date