Anxiety & OCD Center

Dr. Erwin Consulting®

ADULT CLINICAL HISTORY QUESTIONNAIRE

Patient Name _____ Date _____

Address _____ Email 1: _____

_____ Email 2: _____

Telephone (Home)_____ Is it OK for us to call you at this #? Yes No

(Work) _____ Is it OK for us to call you at this #? Yes No

(Cell) _____ Is it OK for us to call you at this #? Yes No

Date of Birth_____ Age_____ Gender_____

Referral Source _____

Reason for Evaluation: _____

_____

List current psychotropic medications (dose, timeframe, prescriber):

_____

_____

_____

_____

_____

_____

Physician's Name _____

Physician's Telephone # _____

Physician's Address _____

Psychiatrist's Name _____

Psychiatrist's Telephone # _____

Psychiatrist's Address _____

Highest Level of Education Completed _____

Occupation _____

PSYCHIATRIC HISTORY

Have you ever received counseling or therapy? Yes ____No ____

If yes: Reason:_____

Has it been beneficial?_____

Name of therapist(s) and duration of treatment: _____

Have you required inpatient or day treatment?: _____

Please list any previous psychotropic medications (dose, timeframe, prescriber):

_____

_____

Have you ever had psychological or educational testing?: _____

ANXIETY SYMPTOMS

List common worries and situations that trigger worry:

_____

_____

What do you do to cope with worry?

_____

_____

What do family members and loved ones do to help you cope with worry?

_____

_____

MOOD SYMPTOMS

Describe your general mood (happy, sad, irritable, apathetic):_____

Do you have thoughts of death, suicide, or harm towards others?_____

Do you engage in cutting or other forms of self-mutilation?_____

Do you experience hallucinations or delusions (hearing voices, seeing visions, unusual beliefs)?_____

MARITAL AND FAMILY HISTORY

Marital status _____

Spouse's name _____ Spouse's occupation _____

Number of children_____ Number of children living at home _____

MEDICAL HISTORY

Please describe your physical health and whether you have chronic medical conditions: _____

_____

Please list current non-psychotropic medications (including vitamins or herbal remedies) and doses:

_____

FAMILY HISTORY

Please describe history of mental health issues or learning difficulties among family members:

Parents:_____

Siblings:_____

Mother's Family:_____

Father's Family:_____