Fort Wayne Psychiatry, PC
Pre- evaluation Questionnaire

Patient name: Date of Birth

How did you hear about us?

Reason for Appointment:

How many psychotherapists/counselors have you seen in past for this problem and related problems?:

What has been your experience in psychotherapy/counseling so far:

Presently in psychotherapy/ counseling with:

Any previous psychological testing? Do you have reports?

Have you been hospitalized for psychiatry problems? Yes / No. If yes, how many times?___ . When was the last time_____

What is your opinion of psychiatric medications?

How many psychiatrists have you seen previously for medication management?

What has been your experience with medication so for?

Have you attempted suicide in the past?

Do you physically hurt yourself?

Do you have thoughts of seriously harming yourself or others now?

Your education level:
Your work:

Did you have a happy childhood?

Where you raised by your parents?

How was your relationship with your parents growing up?

How is your relationship with your parents now?

Were you abused or molested as a child?

How many times have you been married?

Who do you presently live with?

How many children do you have?

What are the major problems in your present household?

Who is supportive of you at this time?

Are you facing any legal difficulties at this time?

How much difficulty are you having presently in functioning at the your work/ home life/school?

What religious and spiritual values are important to you?

Substance-abuse history:

Substance	Problems and comments
Caffeine	
Smoking	
Chewing tobacco	
Alcohol	
Marijuana	
Cocaine/crack	
Crank	
Narcotic painkillers	
Sedatives	
Inhalants(huffing)	
Amphetamines	

Past substance-abuse treatment:

Family history of psychiatric illness:

Problem/Illness	In Which Family Member
Nervous breakdown	
Depression	
Bipolar disorder	
Anxiety/panic	
Drug abuse	
Alcohol abuse	
Suicide with a gun	
Suicide (other)	
Violent crime	
Survivor of abuse	
Abuser or Molester	

Medication allergies:

Environmental/food allergies:

Last menstrual period:

Birth-control method /Plans for pregnancy (for women only):

Circle all problems present now or in past and strike all problems absent

Allergies Asthma Chronic cough/bronchitis Snoring
Chest pain Heart problems Palpitations Mitral valve prolapse
Swelling of feet High blood pressure Thrombosis On blood thinners
Problem with urination Miscarriages Sexual problems
Sexually Transmitted Diseases Abortions HIV
Weight gain Weight loss Diarrhea Constipation
Liver problems Heartburn/indigestion Nausea and vomiting
Arthritis/muscle pains Numbness or tingling Seizures Stroke
Headaches Ringing in ears Hearing aids Vision problems
Thyroid problems Diabetes mellitus Genetic Problems TB Infections
High sensitivity to medications
Other problems:

Family history of physical illness:

Problem/Illness	In Which Family Member
Diabetes	
Heart disease	
Sudden-death	
Other major illness	

Primary care Physician:
Other doctors seemed regularly:

Current non-psychiatric medications: