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 / YY		

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 / YY	
Date of last symptom	
MM / DD / YY	

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 / YY	
Stop date	
MM / DD / YY	

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 / YY

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

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

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

Date	MM / DD / YY	

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 / YY