PRESCRIBER QUESTIONNAIRE

NAME: ____ **DOB:** ________________

LEGAL NAME, IF DIFFERENT: ____

GENDER IDENTITY: ______________________ **PRONOUNS:** ______________________

Please answer all questions with as much detail as possible, using the reverse side of this sheet as necessary. The more detailed the information, the better your treatment plan will be tailored to your own needs. Please remember ALL information you provide is protected with applicable confidentiality laws.

Please list ALL prescription medications you are taking:

____

____

____

____

Please list ALL over-the-counter medications you are taking:

____

____

____

Please list any herbal supplements you are using:

____

____

____

Do you have any medication allergies? Yes / No If yes, please list:

____

____

Please check any complementary or alternative treatments you are using:

_____ Chiropractic

_____ Acupuncture

_____ Homeopathic

_____ Other ____

Mental Health History

Do you or your immediate family (parents, grandparents, siblings, children) have a history of:

	Self	Family
Depression	Yes / No	Yes / No / Unknown
Bipolar Disorder	Yes / No	Yes / No / Unknown
Anxiety	Yes / No	Yes / No / Unknown
Panic Attacks	Yes / No	Yes / No / Unknown
Obsessive-Compulsive Disorder	Yes / No	Yes / No / Unknown
Post-Traumatic Stress Disorder	Yes / No	Yes / No / Unknown
ADHD	Yes / No	Yes / No / Unknown
Sleep Problems	Yes / No	Yes / No / Unknown
Schizophrenia	Yes / No	Yes / No / Unknown
Eating Disorder	Yes / No	Yes / No / Unknown
Borderline Personality Disorder	Yes / No	Yes / No / Unknown
Substance Use Disorder	Yes / No	Yes / No / Unknown
Dementia	Yes / No	Yes / No / Unknown

Other: ____

Have you recently been under the care of another mental health provider? Yes / No

If yes, please provide name and phone number: ____

Are you currently working with a therapist? Yes / No

If yes, please provide name and phone number: ____

Have you ever been hospitalized for mental health care? Yes / No

If yes, please provide when and where:____

Have you ever been a victim of abuse? Yes / No Current / Past

If yes, please indicate type: Physical / Sexual / Emotional

If yes, have you received help? Yes / No

Substance Use History

______ No substance use currently or in the past.

______ No substance use currently or in the past except for tobacco products and/or alcohol.

Tobacco Products: Yes / No Current / Past

Daily quantity __________ How many years? __________

Alcohol: Yes / No Current / Past

Beer Wine Liquor Other Daily Quantity? _________

How many times per week?________ For how long? __________________

Any signs of withdrawal? Yes / No Any signs of tolerance? Yes / No

Have you ever experienced: Blackouts Seizures Shakes

Days sober past month _____ Months sober past year ______ Longest sobriety _________

Cannabis: Yes / No Current / Past

Daily quantity ________ How many times per week? _______

Date of last use ________ For how long? __________

Days sober past month _______ Months sober past year________ Longest sobriety ________

Cocaine: Yes / No Current / Past

Daily quantity _______ How many times per week? __________

Date of last use ________ For how long? _________________________________

Days sober past month _____ Months sober past year ______ Longest sobriety_____

Stimulants: Yes / No Current / Past

Daily quantity _______ How many times per week? __________

Date of last use ________ For how long? _____________________

Days sober past month _____ Months sober past year ______ Longest sobriety_____

Any signs of withdrawal? Yes / No Any signs of tolerance? Yes / No

Opiates: Yes / No Current / Past

If yes, what kind (heroine, pain pills, etc) _____________________________

Daily quantity _______ How many times per week? __________

Date of last use ________ For how long? _____________________

Days sober past month ______ Months sober past year ______ Longest sobriety _____

Any signs of withdrawal? Yes / No Any signs of tolerance? Yes / No

Prescription Pills: Yes / No Current / Past

If yes, what kind (Valium, Xanax, etc) _______________________________________

Daily quantity ________ How many times per week? __________

Date of last use _________ For how long? _____________________

Days sober past month ______ Months sober past year ______ Longest sobriety ______

Any signs of withdrawal? Yes / No Any signs of tolerance? Yes / No

Inhalants: Yes / No Current / Past

Daily quantity _______ How many times per week? __________

Date of last use ________ For how long? _____________________

Days sober past month ______ Months sober past year ______ Longest sobriety _____

PCP: Yes / No Current / Past

Daily quantity _______ How many times per week? __________

Date of last use ________ For how long? _____________________

Days sober past month ______ Months sober past year ______ Longest sobriety _____

LSD: Yes / No Current / Past

Daily quantity _______ How many times per week? __________

Date of last use ________ For how long? _____________________

Days sober past month ______ Months sober past year ______ Longest sobriety _____

Ecstasy: Yes / No Current / Past

Daily quantity _______ How many times per week? __________

Date of last use ________ For how long? _____________________

Days sober past month ______ Months sober past year ______ Longest sobriety _____

Other: Yes / No Current / Past

Daily quantity _______ How many times per week? __________

Date of last use ________ For how long? _____________________

Days sober past month ______ Months sober past year ______ Longest sobriety _____

Have you ever experienced consequences of substance use?

_______ social impairment _______ occupational impairment

_______ legal problems _______ medical problems

Have you ever attempted to quit on your own? Yes / No Current / Past

If yes, please provide details____

____

Have you ever had outpatient substance use treatment? Yes / No Current / Past

If yes, please provide details____

____

Have you ever had inpatient substance use treatment? Yes / No Current / Past

If yes, please provide details____

____

Have you ever been to AA or other self-help groups? Yes / No Current / Past

If yes, please provide details____

____

General Health History

Do you or your immediate family (parents, grandparents, siblings, or children) have a history of any of the following? Please circle your response.

	Self	Family
Diabetes	Yes / No / Current / Past	Yes / No /
Unknown		
High Cholesterol	Yes / No / Current / Past	Yes / No /
Unknown		
Thyroid Condition	Yes / No / Current / Past	Yes / No /
Unknown		
High Blood Pressure	Yes / No / Current / Past	Yes / No /
Unknown		
Heart Attack	Yes / No / Current / Past	Yes / No /
Unknown		
Migraine Headaches	Yes / No / Current / Past	Yes / No /
Unknown		
Tension Headaches	Yes / No / Current / Past	Yes / No /
Unknown		
Sinus Problems	Yes / No / Current / Past	Yes / No /
Unknown		
Stroke	Yes / No / Current / Past	Yes / No /
Unknown		

Seizure Disorder Yes / No / Current / Past Yes / No /
Unknown

Head Trauma Yes / No / Current / Past Yes / No /
Unknown

Confusion Yes / No / Current / Past Yes / No /
Unknown

Memory Loss Yes / No / Current / Past Yes / No / Unknown

HIV Yes / No / Current / Past Yes / No / Unknown

Hepatitis Yes / No / Current / Past Yes / No / Unknown
If yes, what kind: A B C

Self Family

STIs Yes / No / Current / Past Yes / No / Unknown

If yes, what type?____

Cancer Yes / No / Current / Past Yes / No / Unknown

If yes, what type?____

Respiratory (lung) Problems Yes / No / Current / Past Yes / No / Unknown

If yes, what type?____

Heart Problems Yes / No / Current / Past Yes / No / Unknown

If yes, what type?____

Stomach Problems Yes / No / Current / Past Yes / No /
Unknown

If yes, what type?____

Bowel Problems Yes / No / Current / Past Yes / No / Unknown

If yes, what type?____

Kidney/Bladder Problems Yes / No / Current / Past Yes / No / Unknown

If yes, what type?____

Neurological Problems Yes / No / Current / Past Yes / No / Unknown

If yes, what type?____

Vision Problems Yes / No / Current / Past Yes / No / Unknown

If yes, what type?____

Hearing Problems Yes / No / Current / Past Yes / No / Unknown

If yes, what type?____

Other Medical Problems Yes / No / Current / Past Yes / No / Unknown

If yes, what type?____

____

____

Are you currently under the care of a primary care physician? Yes / No

Please provide name and phone number: ____

Last physical exam: ______________________________ Last tetanus shot: ________________________

Have you ever had surgery? Yes / No

If yes, what type and when? ____

____

_

Have you ever had a blood transfusion?

If yes, why and what type?____

Have you ever shared needles? Yes / No Current / Past

If applicable:

Last PAP test: _______________

Last period: _________ Number of pregnancies: ________ Number of living children: _________

What type(s) of birth control do you use? ____

____ ___________________________

Patient / Parent or Legal Guardian Signature Date