Name: ______________________ Date of Birth: ____/____/____

Patient Questionnaire

Patient Name: ______________________ Todays Date: ____/____/20____

Date of Birth: ____/____/____ Age: ______ Gender: ______ Marital Status: ______

SS#: ____-____-____ Primary Language: ______ Race: ______ Hispanic: ______

Address: ______________________

City: ______________ State: ______ Zip: ______

Home Phone: (____) ____-____ Cell Phone: (____) ____-____ Work Phone: (____) ____-____

Email: ______________@__________.______

Contact Preference: ______________________

I Consent to have detailed messaged left on the preferred contact number? o YES o NO

Emergency Contact Name: ______________________ Phone: (____) ____-____

Primary Care Physician: ______________________ Phone: (____) ____-____

Referred By: ______________________ Phone: (____) ____-____

List Other Doctors: ______________________ Phone: (____) ____-____

Employer: ______________________ Work Phone: (____) ____-____

Responsible Party: ______________ Date of Birth ____/____/____

Relationship: ______________ Phone: (____) ____-____ SS#: ____-____-____

Primary Insurance: ______________________

Policy Holder Name: ______________ Insured Member: ______________

Address: ______________________

Group #: ______________ Policy #/ Member ID: ______________

Secondary Insurance: ______________________

Policy Holder Name: ______________ Insured Member: ______________

Address: ______________________

Group #: ______________ Policy #/ Member ID: ______________

Is the purpose of this evaluation to obtain disability? o YES o NO

Intended for use in the offices of:
Juan Cabrera Jr., MD & Mindie Halterman, PMHNP
Revised Jan. 2021

Name: ______________________________ Date of Birth: ______/______/______

PAST MEDICAL HISTORY

Do you have any of the following?	YES	NO
Depression		
Previous known suicide attempt		
Self-Inflicted Injury		
Anxiety		
Alcohol Abuse		
Drug Abuse		
Bipolar Disorder		
Schizophrenia		
Eating Disorder		
Obesity		
Diabetes		
High blood pressure		
High cholesterol		
Heart Disease (CAD)		
Heart Attack		
Kidney problems		
Liver Disease		
Stroke		
TIA		
Glaucoma		
Migraine		
COPD		
Glaucoma		
Migraine		
Seizures		
HIV		
Hyperthyroidism		
Hypothyroidism		
Obstructive Sleep Apnea		
Sleep Disorders		
Alzheimer's Disease		
Vascular Dementia		
Traumatic Brain Injury		
ADHD		
Asperger Syndrome		
Autism		
Learning disability		

Other Past Medical History:

____

____

____

FAMILY HISTORY

Does anyone in your family have the following?	YES	NO
Psychiatric condition		
Alcoholism		
Substance abuse		
ADD/ ADHD		
Depression		
Postpartum depression		
Diabetes		
Heart Disease		
High Cholesterol		
Hypertension		
Stroke		
Epilepsy		
Thyroid disease		
Liver disease		
Kidney disease		
Cancer, other unspecified		
Huntington's disease		
Other inherited genetic or chromanol disorder		

Other family history:

____

____

____

SURGICAL HISTORY

Have you had any of the following surgeries?	YES	NO
Appendectomy		
Back Surgery		
Colectomy		
Coronary artery bypass graft		
Total Hysterectomy		
Thyroidectomy		
Tubal Ligation		
Anesthesia complications		
Cardiac stent		

Other Surgical History:

____

____

____

Name: ______________________________ Date of Birth: _____/_____/_____

SOCICAL HISTORY

Social History	YES	NO
Current every day smoker		
Current some day smoker		
Former Smoker		
Never Smoked		
Smoker, status unknown		
Unknown if ever smoked		
Other tobacco use		
Passive smoker		
Alcohol use		
Alcohol abuse		
Past alcohol abuse		
Current drug user		
Past drug user		
Substance abuse: amphetamine		
Substance abuse: cocaine		
Substance abuse: heroin		
Prescription drug abuse		
Exercise		
Follows a diet		
Caffeine		
Lives alone		
Children		
Employed		
Received disability payments		
Abused		
Sexually active		
Married		
Divorced		
Separated		
Single		
Widowed		
Siblings		
Military problems		
High school diploma		
Attending higher education college		
Received higher education college education		
Received higher education at technical college		
Received university education		
Received postgraduate education		
Received post doctorate education		

Other:

____

____

____

GENERAL SYMPTOMS

Do you have any of the following?	YES	NO
Insomnia		
Excessive day and night-time sleepiness		
Increased appetite		
Decreased appetite		
Recent weight change		
Weight gain		
Weight loss		
Pain		
Night sweats		
Fever		
Chills		
Dizziness		
Fatigue		
Weakness		
Activity level normal		

Other:

____

____

____

PSYCHIATRIC SYMPTOMS

Do you experience any of the following?	YES	NO
Depression		
Frequent crying		
Feeling hopeless		
Sadness		
Loss of interest		
Loss of initiative		
Trouble with focus, concentration, or decision making		
Feeling angry		
Mania		
Excessive energy		
Anxiety		
Nervousness		
Panic Attack		
Auditory hallucinations		
Visual hallucinations		
Delusions		
Suicidal thoughts		
Homicidal thoughts		

Other:

____

____

____

Name: ______________________________ Date of Birth: ____/____/____

Neurological Symptoms

Do you experience any of the following?	YES	NO
Headaches		
Migraines		
Seizures		
Fainting		
Lightheadedness		
Short term memory problems		
Long term memory problems		
Confusion/ disorientation		
Change in personality		
Change in vision		
Trouble hearing		
Trouble smelling		
Change in taste		
Speech changes		
Facial weakness/ numbness		
Drooling		
Weakness/ numbness in arm		
Weakness/ numbness in leg		
Loss of limb use		
Tremors		
Involuntary movements		
Trouble with coordination		
Difficulty walking		
Balance problems		
Losing control of urine or bowel		

Other:

____

____

____

Have you ever been hospitalized in a psychiatric facility?

o YES o NO

How many times? ________

When? ______________________________

What is (are) your chief concern(s) for seeking help?
Please be specific.

____

How do you spend your time? What are your hobbies or interests?

____

What has been tried to treat your problem? What has worked best for this problem?

____

Name: ______________________________ Date of Birth: _____/_____/_____

What pharmacy do you use to fill prescriptions?

Name: ______________________ Phone: (____) _____-______

Address: ____

City: __________________ State: ____________ Zip: __________

Drug Allergies (please indicate if you have none) Do Not Leave Blank

____

____

Current Medications Name and Dosage	Directions per bottle How is it taken?	Prescribed by