Craig A. Brown M.D. Diplomate American Board of Psychiatry and Neurology
480 4th Ave Ste 511 Chula Vista, CA. 91910
Telephone: 619-426-0370/Fax: 619-426-0676

Patient Questionnaire

A Note on Patient Selection:

The steps we follow are first to assess the nature of the problem to learn if the problem is one that I treat; that requires disclosing personal information about oneself and providing information related to your medical history.

Once I know that the problem is one that I treat then we send the insurance information to our billing vendor to learn whether the insurance is one that supports psychiatric care, and whether there are restrictive limits on the number of visits, or high co-pays - all of which affect access to psychiatric care, but which are not knowable until the billing vendor explores those issues directly with the insurer.

Insurers often create barriers to psychiatric care by creating such limits or making co-pays so burdensome that patients will not sustain visit frequency needed for treatment of their problem. We treat prospective patients from a variety of insurers, but at times we can no longer take more patients from a given insurer in order to keep the mix of insurers in balance.

After those steps we decide whether we can go forward with care.

If a patient is not accepted as a new patient the personal information patients disclose about themselves is kept on file for about 6 months and then shredded.

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Patient Questionnaire

DATE_____

NAME

_____
Last Middle First

REFERRAL HISTORY:

How did you find us (via a referral, web search, recommendation)?
_____

Please provide the name and phone number of you family physician:
_____

Please provide the name and phone number of any specialists that you consult:
_____

IDENTIFYING AND BILLING INFORMATION:

Social Security number: _____
Driver's license number: _____
Age: _____
Date of Birth: _____
Home phone number: _____
Cell phone number: _____
Work phone number: _____
In what country, city, were you born: _____

OCCUPATION

Job description: _____

If not employed currently when was the last time that you worked?
_____

EDUCATION HISTORY

Highest grade you completed? _____
Name of high school? _____
Name of college (if applicable)? _____
Additional Degrees (if applicable)? _____

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MARITAL HISTORY

If you are currently married:

What year were you married? _____

What is the name of your spouse? _____

Have you been married more than once? If so, how many times? _____

If you are currently divorced what year did you and your partner separate? _____

FAMILY HISTORY:

If you have children, please list their names and ages:

_____

_____

_____

_____

_____

Psychiatric Illnesses:

To the best of your knowledge, has anyone in your immediate family struggled with a problem similar to yours? _____

What family member? _____

If more than one family member has struggled with a psychiatric illness similar to yours, please list their names and whether they were treated for said problem:

_____

_____

_____

PSYCHIATRIC HISTORY

Previous Episodes:

Have you had a similar episode in the past? If so, please list the dates of previous episodes: _____

Treatment:

Were you treated for a similar episode? _____

Who treated the episode? _____

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Medication:

If you were treated with medication, please list the name and dosage of the medication(s): _____

Diagnosis:

Have you ever been officially diagnosed with a psychiatric diagnosis? If so, what was it?

_____

PROBLEM HISTORY:

Severity Rating: Please use the numbers below to rate the severity of the problem(s) for which you are seeking help. A score of 0 indicates no problem, and a score of 10 indicates the worst level of problem.

No Problem	0	1	2	3	4	5	6	7	8	9	10	Worst Problem

Please use select from this list the problem(s) for which you are seeking help and use the severity numbers to grade each of the problems for which you are seeking help
(Or if you would rather, use you own words to describe your problem

Check all that Apply	**Problem Type**	**Severity Level** *(0=None: 10=Worst)*
	Anxious	
	Worried	
	Fearful	
	Trouble Concentrating	
	Sleep Problems	
	Depressed	
	Sad	
	Avoidance of Friends/Family	
	Feelings of Worthlessness	
	Loss of Ability to Experience Pleasurable Activities	
	Loss of Motivation	
	Loss of Energy	
	Mood Swings	
	Irritability	
	Anger	
	Stress at Work	
	Stressful Medical Problems	
	Financial Stress	
	Recent Death or Loss of a Family Member	

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DRUG AND ALCOHOL HISTORY

Drugs & Alcohol:

Are there, or were there, any drug or alcohol problems in your family?

_____

If so, which family members have struggled with drugs or alcohol?

_____

Have you ever abused alcohol? _____

If so, how old were you when you last abused alcohol? _____

Have you ever used drugs? _____

If so, how old were you when you last used? _____

Have you ever been treated for a drug or alcohol problem, and if so, please describe the treatment: _____

_____

FUNCTIONAL HISTORY

What aspect of your problem do you feel interferes the most with your day to day life?

_____

Has your problem made it difficult or impossible to do the things that you do every day?

_____

What things in particular have become difficult? _____

Have you ever had to miss work for the problem that you came here for help? _____

How many times? _____

ABUSE AND OR MOLESTATION HISTORY

Have you ever been abused? _____

If you were abused as a child, describe it:

Emotional abuse? _____

Physical abuse? _____

Sexual abuse? _____

If you were abused as an adult, please describe it:

Emotional abuse? _____

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Physical abuse? _____

Sexual abuse? _____

If yes to any of the above, please answer the following questions:

Who abused you? _____

How often? _____

GENERAL MEDICAL HISTORY

If you have any additional medical problems, please list them below:

_____

_____

_____

_____

If you are currently taking any medications, please list the names of the medications and dosages in the spaces provided:

_____

_____

_____

_____

If you have you ever been hospitalized, please include a list of list below, beginning with the most recent dates:

Hospitalization	Date	Location	Reason for Hospitalization