



Brief Psychiatric Questionnaire

Medical History (Check any current or previous health problems)

- | | |
|--|-------------------------------|
| Anxiety or panic attacks | Appetite or weight changes |
| Alcohol or drug problems | Asthma or lung problems |
| Emotional, physical, or sexual abuse | Family psychiatric problems |
| Forgetfulness resulting in accidents | Hallucinations |
| Frequent pain such as head or backache | Head injury or seizures |
| Heart problems or high blood pressure | Loss of energy or motivation |
| Serious illness or operation | Suicidal thoughts or attempts |
| Stroke or prolonged fainting spells | Thyroid/endocrine problems |
| Several unexplained physical problems | Violent behavior |
| Problems not listed above: _____ | |

Habits (Describe below if you check any of these)

- | | |
|------------------|----------------|
| Smoke Cigarettes | Drink Caffeine |
|------------------|----------------|
- Use Alcohol or Recreational Drugs
- Have you ever felt you should cut down on your use of alcohol/recreational drugs?
- Have people annoyed you by criticizing your use of alcohol/recreational drugs?
- Have you ever felt bad or guilty about your use of alcohol/recreational drugs?
- Have you ever had a drink/used drugs first thing in the morning to steady your nerves/relieve a hangover?
- _____
- _____

Prescribed Medications and Drug Allergies

Take prescribed medications (If so, please list name and dosage): _____

Allergic to any prescription medications (If so, please list name): _____

Background Information

The highest level of school I completed during my formal education was: _____

During adulthood, I have worked as: _____



Stressful Life Events ('x' if it happened to you in the past or 'xx' if during the past 12 months):

Death of spouse	Marital separation	Divorce
Jail term	Death of a friend or family member	Personal injury or illness
Marriage	Problems with family members	Sexual difficulties
Changing residence	Gain of new family member	Child leaving home
Retirement	Spouse starts or ends work	Fired from job
Work dissatisfaction	Financial/legal problems	
Change in social or recreational activities		

Instructions: Please enter a number from 1 to 4 by each item.

Scale: 1= Rarely 2= Sometimes 3= Often 4= Usually

Anxiety

1. I feel more nervous or anxious than usual.
2. I feel afraid for no reason at all.
3. I get upset easily or feel panicky.
4. I feel like I'm falling apart and going to pieces.
5. I feel everything is terrible and something bad will happen.
6. My arms and legs shake and tremble.
7. I have headaches and neck and/or back pains.
8. I feel weak and fatigue easily.
9. I never feel calm or able to sit still.
10. I can feel my heart beating fast.
11. I am bothered by dizzy spells.
12. I feel like fainting.
13. I have trouble breathing in and out easily.
14. I get numbness and tingling in my fingers or toes.
15. I am bothered by stomachaches or indigestion.
16. I have to empty my bladder often.
17. My hands get cold and/or sweaty.
18. My face gets hot and blushes.
19. I have trouble falling asleep and getting a good night's rest.
20. I have nightmares.

TOTAL _____



Depression

1. I feel downhearted, blue, or sad.
2. Morning is when I feel the worst.
3. I have crying spells, or feel like having crying spells.
4. I have trouble sleeping through the night.
5. I can't eat as much as I used to eat.
6. I don't enjoy talking to or being with my friends.
7. I am gaining or losing weight without dieting.
8. I have trouble with constipation.
9. My heart beats faster than usual.
10. I get tired for no reason.
11. My mind is not as clear as it used to be.
12. I don't find it easy to do the things I used to do.
13. I am restless and can't keep still.
14. I am not hopeful about the future.
15. I am more irritable than usual.
16. I am having a difficult time in making decisions.
17. I feel worthless and not needed.
18. My life is pretty empty.
19. I feel others would be better off if I weren't here.
20. I can't enjoy the things I used to do.

TOTAL

Patient Name _____ Date _____