BRENNAN INSTITUTE FOR MIND-BODY HEALING

Consultation Questionnaire

The information in this questionnaire will provide us with some background of your situation. When added to our meetings together, it will help us find an effective approach to treatment. Please add any additional relevant information, using the reverse side of pages if necessary. As required by law, your replies will be held in confidence.

Name: ______________________________ Date of Birth/Age: ___________. Today's Date: _________

Address/City/State/Zip Code: ____

Contact Information: Cell: _________________________
Home: _________________________
Work: __________________________
Email: __________________________

Emergency Contact Information: Name: _________________________
Address: _________________________
Phone: _________________________

Who referred you to us? ________________________

What is the main concern that led you to consult me? ____
____

MEDICAL HISTORY

Medical Illnesses
Have you had any illnesses in the past? Yes_____ No_____
What were they? ____
____

Do you have any illnesses at present? Yes_____ No_____
If yes, which are they? ____
____

Date of your most recent physical exam? ___________
Physician Name: ____________________ Phone: _________________________
Address: ____

Do you authorize me to communicate with your physician or other provider(s)? Yes ____. No ____

Surgical/Medical Conditions
Have you had surgical operations or injuries? Yes____ No____
If yes, what were they and when did they happen? ____

____

Have you ever had a head injury? Yes____ No____
If yes, did you lose consciousness? Yes____ No____
If yes, please describe the details, when and how it occurred? ______________________________

____

Have you ever had seizures? Yes____ No____
If so, what are they like? ____

____

MEDICATION HISTORY
Which medications are you taking now *(medical or psychiatric)?*

Drug Dose Frequency Prescribing Physician

____

____

Past medications:
Drug Dose Frequency Prescribing Physician

____

____

Non-prescription drugs:
Drug Dose Frequency

____

____

Do you or have you used recreational or illegal drugs? Yes____ No_____
If yes, which drugs and how much/often? ____

____

Do you drink alcohol? Yes____No____
Have you ever tried to cut down on how much you drink? Yes____ No_____
Are you annoyed at comments about your drinking? Yes____ No_____
Have you felt guilty about anything resulting from your drinking? Yes____ No____
Do you feel better if you have a drink early in the day? Yes____ No____

Beverages with caffeine *(circle those that apply):*
Coffee or tea: ____cups per day Colas: ____cans per day

PSYCHIATRIC HISTORY

Hospitalizations

Have you ever been hospitalized for a psychiatric disorder? Yes____ No____

If yes, what was the disorder, which hospitals and what were the dates? ________________________________

____

Outpatient Mental Health Treatment

Have you ever had treatment for a mental health issue? Yes____ No____

If yes, please describe the problem or mental health diagnosis? ________________________________

____

When and where did you receive treatment?

Treatment	Contact/Provider	Dates
________________________	____________________	_____

What type of treatment? *(e.g., psychotherapy, partial hospitalization, medication, behavior therapy, other)* _

____

Name of former therapist/psychiatrist: ____________________ Phone: ____________________

Address: ____

Do you authorize me to communicate with him/her? Yes_____ No______

BRIEF REVIEW OF SYMPTOMS

SYMPTOM/PROBLEM—Check all that apply. If checked, describe in more detail & note the date it began.

- ☐ Decreased vision/eye pain
- ☐ Wear eyeglasses/contacts
- ☐ Dizziness/vertigo
- ☐ Earaches/buzzing or other sounds
- ☐ Decreased hearing
- ☐ Difficulty swallowing
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Decreased energy
- ☐ Difficulty concentrating/distractibility
- ☐ Difficulties with organization
- ☐ Impulsivity
- ☐ Cough/asthma
- ☐ Abdominal pain
- ☐ Menstrual/reproductive problems or infections
- ☐ Eating problems
- ☐ Decreased appetite
- ☐ Using laxatives, diuretics, or diet pills to lose weight
- ☐ Nausea, vomiting, diarrhea
- ☐ Weight loss/gain
- ☐ Frequent or severe headaches
- ☐ Convulsions or seizures
- ☐ Self-induced vomiting (with or without ipecac)
- ☐ Depression

- ☐ Anxiety/panic attacks
- ☐ Avoidance of public places in order to avoid panic attacks
- ☐ Sleep difficulty
- ☐ Decreased motivation
- ☐ Racing thoughts
- ☐ Suicidal thoughts/fears
- ☐ Suicide wishes/plans/attempts
- ☐ Homicidal thoughts/wishes
- ☐ Homicidal plans/violent acts
- ☐ Seeing things that other people don't see
- ☐ Hearing things that other people don't hear
- ☐ Legal history-trouble with the law
- ☐ Loneliness/isolation
- ☐ Repetitive unwanted thoughts or actions
- ☐ Helplessness/guilt
- ☐ Checking things multiple times to make sure they are in place
- ☐ Washing things multiple times to make sure they are clean
- ☐ Nightmares
- ☐ Flashbacks
- ☐ Compulsive or addictive behaviors that are hard to control

Does your primary care physician know about the symptoms you have circled? Yes ____. No ____

Have you ever been exposed to abuse? Yes ____ No _____

Physical ______ Sexual _________ Emotional ________

Who was involved? ____

____

Are you distressed about any aspect of your appearance? Yes _____ No _____

FAMILY MEDICAL HISTORY

Marital Status: _______ Single _____ Married _____ Widowed _____ Divorced

If married, date of wedding? _____________

Husband/wife's date of birth _____________

Occupation of husband/wife ____

If widowed, date of spouse's death ___________

Cause of death ____

If separated/divorced, date _________________

Reason ____

<u>Children</u>

Name	*Age*	*Date of Birth*
___________________________	_______	______________
___________________________	_______	______________

Do you engage in safe sex? _______ Always _______ Sometimes _______ Never

Do you have any sexual concerns? Yes____ No____

If yes, please describe: ____

____

Others currently living in household and their relationship to you

Name	*Relationship*
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

Mother's name ________________ Age______
If deceased, date and cause of death _______________________
Serious illness____

Father's name_________________ Age_____
*If deceased, date and cause of death*_______________________
Serious illnesses ____

Brothers and sisters

Name	Age	Serious illness
__________	______	______________________________
__________	______	______________________________
__________	______	______________________________

FAMILY PSYCHIATRIC HISTORY

Has anyone in your family ever had a psychiatric disorder? Yes____ No____
Have any of the following family members had psychiatric disorders *(including depression, mania, schizophrenia, drug or alcohol abuse, obsessive-compulsive disorder, panic disorder, phobias, suicide)*? Please indicate diagnosis and the name of the individual.

Your sons or daughters________________
Father___________________
Mother________________
Brothers_________________
Sisters__________________
Maternal grandparents_________________
Paternal grandparents_________________
Uncles/aunts/cousins__________________

DEVELOPMENTAL HISTORY

Was your mother exposed to stresses, drugs, or dangerous substances while pregnant with you?
Yes ______ No ______
If yes, what were they? ____

____

Were there any difficulties with your birth? Yes _____ No _____
*If yes, what were they?*____

____

Have you had any recent stresses or relevant stresses in the past? Yes _____ No _____
If yes, please list them: ____

____

ADAPTIVE HISTORY

Which stresses have you overcome in the past? ______________________________

____

How did you do it? ____

____

What was the best period of your life? ______________________________

____

What are your personal strengths? ______________________________

____

EDUCATIONAL HISTORY

Name of School/Location

Elementary	________________	Dates	________________
Secondary	________________	Dates	________________
College	________________	Dates	________________
Postgraduate	________________	Dates	________________

Have you had any history of difficulties at school? Yes _____ No _____
If yes, please describe: ____

____

OCCUPATIONAL HISTORY

Current Occupation: ______________________

Past Occupations:

Dates	Job Titles
________________	____
________________	____
________________	____
________________	____

Prior Military Service:
Branch: ____________________ Dates of Service: ________ Discharge:______________

Have you had any history of difficulties at work? Yes _____ No_____
If yes, please explain: ____

____

Have you had any problems with the law? Yes_____ No _____
_______ Differed Prosecutions ____ Prior Charges. _______Convictions. ________DUIs
If yes, please explain: ____

____

Form Completed By:

Name: ____ **Date:** _____________