DENNIS GLICK, MD
INITIAL PATIENT QUESTIONNAIRE

NAME OF PATIENT: AGE:

NAME OF PERSON FILLING OUT FORM: ______________________________

RELATIONSHIP TO PATIENT: __________________ TODAY'S DATE: ____________________

CURRENT PSYCHIATRIC SYMPTOMS - - CIRCLE ALL THAT APPLY:

Suicidal thoughts Suicidal plans Past suicide attempts: Y N

Self-harm behavior Verbal or physical abuse toward others Inattentiveness

Depressed mood Loss of interests Feelings of guilt Withdrawal from life

Change in Energy Change in sleep Hopelessness Worthlessness

Less sleep/higher energy Racing thoughts/rapid speech Elated or irritable mood

Anxiety Worry/tension/on edge Panic attacks Repetitive behaviors

Hearing voices Unreal ideas Failing memory Substance use concern

Other (please list):

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CURRENT PSYCHIATRIC MEDICATIONS:

MEDICATION	STRENGTH	# PILLS/DOSE	TIME(S) YOU TAKE PILLS

FAMILY MEMBERS WITH PSYCHIATRIC DISORDERS (CIRCLE ALL THAT APPLY):

Anxiety/Panic Attention Deficit Disorders Dementia Depression

Manic Depression/Bipolar Disorder Obsessive-Compulsive Disorder

Schizophrenia Substance Abuse

PAST HISTORY OF PSYCHIATRIC TREATMENT:

HOSPITALIZATIONS (YEAR, DURATION, INPATIENT OR DAY PROGRAM):

PAST MEDICATION TRIALS (DRUG, DOSE, DURATION):

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MEDICAL HISTORY:

CURRENT MEDICAL CONDITIONS	MEDICATIONS TAKEN

LIST ALLERGIES TO MEDICATIONS:

NAME AND CONTACT INFORMATION FOR THERAPIST/COUNSELOR:

NAME AND CONTACT INFORMATION FOR PRIMARY PHYSICIAN/PEDIATRICIAN:

DATE OF LAST PHYSICAL EXAM: