Bridge Health Services
601 S. Rancho Dr. Ste. D29, Las Vegas, NV 89106
Phone Number: 7028430551
Email: bridgehscg@gmail.com

ADULT PSYCHIATRIC QUESTIONNAIRE

Please carefully fill this form prior to your first appointment in order to help us reduce the wait time and cost of gathering this information at out office. We appreciate your cooperation and patience.

Patient's Name (Last, First, MI) ____

Date of Birth: ____________________ Age: _________________ Sex: M / F

Race: _____________________________ Place of Birth: __________________________________

Address: ____

City: ____________________________ State_____________________ Zip code______________

Phone Number (Mobile) _______________________________ (Home) _____________________

Person completing this form other than the patient: ____________________________________

Relationship to patient: ____

Who referred you to us: ____

Presenting Problem (Include when problem started and contributing stressors)

____

____

____

____

PSYCHIATRIC HISTORY

Have you ever seen a psychiatrist before? (Please list name, location and when):___________

____

Have you ever been admitted to a psychiatric hospital? (Name, when, duration and reason)

____

____

Bridge Health Services
601 S. Rancho Dr. Ste. D29, Las Vegas, NV 89106
Phone Number: 7028430551
Email: bridgehscg@gmail.com

Previous medication Trial and reaction:
____

____

Current psychiatric/Medical medications (Include OTC, Vitamins and herbal meds):

____

____

Pharmacy Name, Address and Phone Number: (Cross street may help) ______________________

____

History of Suicidal/Homicidal ideation (When, plan, treatment):___________________________

____

History of Physical and Sexual Abuse: (Age, who) ____

____

THERAPY HISTORY:

Have you ever had Psychotherapy? Please list when, how long and with who: _______________

____

PAST MEDICAL HISTORY: (Please list current and past medical problems and surgeries) _______

____

____

Hx. of Seizures______________________ Hx. of Head Traumas____________________________

Any Allergies to Medications? (Please list)____

____

SUBSTANCE USE HISTORY (Please list age of first use, frequency of use, last use and problems encountered):

Alcohol: ____

Tobacco: ____

Marijuana: ____

Cocaine: ____

Illicit drugs: ____

Bridge Health Services
601 S. Rancho Dr. Ste. D29, Las Vegas, NV 89106
Phone Number: 7028430551
Email: bridgehscg@gmail.com

SOCIAL & FAMILY HISTORY:

Relationship Status____

Who lives with you (Include children and age) _______________________________________

____

Family history of mental illness (**Depression, Anxiety, Bipolar, Schizophrenia, Learning disability, ADHD/ADD, Sleep problems, Abnormal Movement**), Please list who and diagnosis.

____

____

Family History of completed/Uncompleted Suicide: (please list who and relationship to patient)

____

Please List any childhood trauma:

____

EDUCATION HISTORY:

Highest Level completed: ____________________ School____________________________

Academic performance: Good /Fair/ Poor. IEP / 504 / Special Ed

EMPLOYMENT HISTORY (Please list current and last two jobs if current is less than a year)

____

____

____

LEGAL HISTORY (List year and offense): ___________________________________

____

THANK YOU! We look forward to providing you with the help you need!