VIENNA BEHARIORAL HEALTH

421 CHURCH STREET SUITE B
VIENNA, VA 22180

Today's Date:___________________

Name:___________________________________

Address:____

DOB:___________________ Age:______ Gender:______ Race:_____
Marital Status___________

Medical Questionnaire

1. What is the major problem for which you are seeking help at this time?

____

____

____

2. When did this problem begin?

____

3. Have you ever had this problem before in your life? If so, when:

____

____

4. Have you been treated for the above problem or any mental health issues before:

____

____

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____
____

5. Please list all psychiatric medications you have ever taken including anti-depressants, mood stabilizers, anti-psychotics, tranquilizers, sleeping pills and anti-seizure medications: *(Use the back of this sheet if necessary)*

____
____
____
____
____
____
____

6. Vitamins/ Herbal/Non Prescription Remedies that you have used or are currently using:

____
____
____
____
____
____
____
____

7. List all Previous psychiatric hospitalizations: *(Use back of this sheet if necessary)*

Hospital	Location	Dates	Reason	Doctor's Name

8. Alcohol Use per week: Beer (12 oz. cans) _____ Liquor_____ Wine______
Other:____________

9. Tobacco Use: ____________________

10. Caffeinated Drinks per day: __________

11. Illegal Drug Use: *(Use the back of this sheet if necessary)*

Drug	Frequency	Date started	Date stopped

( ) I'd like to discuss this issue in person

12. List the dates of any DUI's, traffic accidents or legal problems currently or in the past:

____

____

( ) I'd like to discuss this issue in person

13. List all medical conditions for which you are currently being treated:

____

____

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____

____

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14. Medication Allergies:

15. Current Medications: *(Use the back of this sheet if necessary)*

Medication	Strength	Frequency	Date started	Prescribed by

16. Have you had any surgeries or been hospitalized? (Please explain)

17. Family History of Medical or Psychiatric Illness:

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18. Are you currently employed? ( )N ( )Y What type of work do/did you do?

____

____

____

19. Have you ever had a work related injury or been on Worker's Compensation? If so, for what and when:

____

____

____

20. Are you on Social Security Disability? If so when did it begin and for what reason?

____

____

21. Highest Level of Education:

____

22. Were you ever in the military? If so, when, what division and type of discharge?

____

23. Have you ever been a victim of trauma? ( ) N ( ) Y
( ) Physically ( ) Sexually (including rape or attempted rape) ( ) Verbally
( ) Emotionally

( ) I'd like to discuss this issue in person

24. Have you ever been arrested or convicted? ( ) N ( ) Y
If yes, was it...... ( ) DUI ( ) Drug-related ( ) Domestic violence ( ) Other

25. Have you ever attended: (If Yes) -
AA ( )Current ( )Past **NA** ( )Current ( )Past

26. Have you ever been treated for substance misuse? ( )N ( )Y

(Please describe when, where and for how long)

___

27. How long have you been using following substances?

___

Substance Use History

	No	Yes/Past or Yes/Now	Route	How Much	How Often	Date/Time of Last Use	Quantity Last Used
Alcohol							
Caffeine (pills or beverages)							
Cocaine							
Crystal Meth-Amphetamine							
Heroin							
Inhalants							
LSD or Hallucinogens							
Marijuana							
Methadone							
Pain Killers							
PCP							
Stimulants (pills)							
Tranquilizers/ Sleeping Pills							
Ecstasy							
Other							

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28. Did you ever stopped using any of the above because of dependence ( )N ( )Y (Please list)____

29. What was your longest period of abstinence?____