VIENNA BEHAVIORAL HEALTH

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:

_____

_____

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

Have you ever used following substances?

Alcohol: ☑ caffeine pills: ☑ Cocaine: ☑ crystal meth/amphetamines: ☑ heroin: ☑
Inhalants: ☑ LSD or hallucinogens: ☑ marijuana: ☑ Methadone: ☑ Pain medicines: ☑
PCP: ☑ stimulants(pills): ☑ tranquilizers/sleeping pills: ☑ Ecstasy: ☑ others: ☑

Did you ever stopped using any of the above because of dependence ☑)N ☑Y (Please List)

_____

What was your longest period of abstinence?_____

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

_____

_____

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

_____

_____

14. Medication Allergies:

_____

15. Current Medications:

_____

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

_____

_____

17. Family History of Medical or Psychiatric Illness:

_____

_____

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

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)

_____

NAME:_____ SIGNATURE:_____ Dated:_____

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