TREASURE VALLEY PSYCHOLOGICAL SERVICES
DR. M. SNIDER, PLLC

Patient Name: _____Date: _____

WHEN RELEVANT, PLEASE CIRCLE YES OR NO FOR THE FOLLOWING QUESTIONS. OTHERWISE, PLEASE ANSWER THE SPECIFIC QUESTIONS ASKED.
(This questionnaire will provide a thorough evaluation necessary for the most appropriate treatment)

Developmental/Childhood History:

Were you born prematurely? YES NO
If yes, how many weeks premature? _____
To your knowledge, were there any complications during your mother's pregnancy with you, or during your birth? YES NO
If yes, what were the complications? _____
To your knowledge, did you meet developmental milestones on time (walking/talking)? YES NO
Did you experience any type of abuse as a child? YES NO
Are your parents divorced? YES NO
If yes, how old were you when they divorced? Age _____
Are you right handed, left handed, or ambidextrous? (please, circle one)
Number of biological brothers___ biological sisters___ half or stepbrothers___ half or stepsisters___
Where were you born? _____ Where were you raised? _____

Psychiatric History:

Have you been diagnosed with any of the following disorders (check all that apply)? YES NO

Depression___	Bipolar/Manic Depressive___	Borderline Personality Disorder___
Anxiety___	Anger Management___	Schizophrenia___
PTSD___	OCD___	Conversion___
Hoarding___	Eating Disorder___	

List any other psychiatric conditions: _____
Have you ever been hospitalized for a psychiatric disorder? YES NO
If yes, length of time: _____ When: _____ Why: _____
_____
Have you ever received outpatient counseling? YES NO
If yes, length of time: _____ When: _____ Why: _____
_____

Medical History:

Have you been diagnosed with any of the following disorders (check all that apply)? YES NO

Epilepsy/Seizures___	Stroke___	MS___	Dementia___
Lyme___	Head Injury___	Lupus___	Diabetes___
High Blood Pressure___	High Cholesterol___	Cancer___	Parkinson's___
Hydrocephalus___	Chronic Pain___	Thyroid Issues___	Heart Surgery___

Carbon Monoxide Poisoning___ ALS (Lou Gehrig's Disease)___ Migraines/Tension Headaches___
List any other medical conditions: _____
_____

Patient Name: _____Date: _____

Educational History:

Education Level Completed: If less than High School, highest grade completed___ High School____
Some college___ AA/AS___ BA/BS___ MA/MS___ Doctorate____
If you attended college, what was your major(s)? _____
Typical Grades in Elementary School_____
Typical Grades in High School _____Final GPA_____
Typical Grades in College _____Final GPA_____
Were you ever diagnosed with a learning disability? YES NO
If yes, what type(s) of learning disability? _____
Did you ever receive special accommodations/special education? YES NO
Did you ever need to repeat a grade(s)? YES NO
If yes, what grade or grades? _____
Behavioral problems in school (Principal's office, skipped school, expelled, suspended)? YES NO

Occupational History:

Are you currently working? YES NO
If yes, what is your occupation? _____
How long have you been working at your current position? _____
If no, what is the reason that you are not working? Retired___ Disability___ Other___
How old were you when you started working at your first job? _____(age)
Types of previous jobs: _____

Legal History:

Have you ever been convicted of any crimes other than minor traffic violations? YES NO
If yes, please explain: _____
_____

Psychosocial History:

Do you drive? YES NO
Do you do other activities without difficulty (cooking, cleaning, bills, personal hygiene) YES NO
Do you exercise? YES NO
If yes, please note how often. Rarely___ Daily___ Weekly___ Monthly___ Other___
Do you live in a house or an apartment? (please, circle one)
Marital Status: S / M / D / W (please, circle one)
If married, how many years? _____
How many times, in total, have you been married? _____
Do you have children? YES NO
If yes, what are their names and ages? _____
_____
What is your ethnicity?_____

Patient Name: _____Date: _____

Family Psychiatric History: (include only <u>your</u> children, parents, grandparents, and/or siblings)

Has anyone in your **above included** family members been diagnosed with the following?

Depression	YES	NO
ADD/ADHD	YES	NO
Bipolar/Manic Depressive	YES	NO
Schizophrenia	YES	NO
Anxiety/PTSD/OCD	YES	NO
Alcohol or Drug Abuse	YES	NO

Other_____

Family Medical History: (include only your children, parents, grandparents, and/or siblings)

Has anyone in your **above included** family members been diagnosed with the following?

Dementia/Alzheimer's	YES	NO
Stroke/TIA's(transient ischemic attack's)	YES	NO
Epilepsy/Seizure Disorder	YES	NO
Multiple Sclerosis (MS)	YES	NO
Diabetes	YES	NO
Cancer	YES	NO
High Blood Pressure	YES	NO
High Cholesterol	YES	NO

Other_____

Substance Abuse History:

Do you CURRENTLY drink alcohol? YES NO

If yes, how often do you drink? _____

If yes, how much do you drink in one sitting? _____

If yes, how long have you been drinking? _____

Have you **abused** alcohol in the past? (<u>does not include occasional drinking</u>) YES NO

If yes, when did you stop drinking alcohol? _____

Do you CURRENTLY use recreational drugs? YES NO

If yes, how often do you use drugs? _____

If yes, what types of drugs do you use? _____

Have you used recreational drugs in the past? YES NO

If yes, what drugs have you used? _____

Have you attended chemical dependency treatment for alcohol and/or drug? YES NO

If yes, when? _____ How long? _____

Have you ever used nicotine? YES NO

If yes, how many years? _____ How much? _____