Pre-Evaluation Questionnaire

Scheduled appointment date:

Scheduled appointment time:

Directions:

Please click inside the text boxes to type in your answers below. Answer questions in a detailed but concise way. Not all questions will be applicable to every patient, depending on age and other factors.

Your telehealth appointment will be through Doxy.me. Once you log into the waiting room, you will be asked to share this file by the provider. Allow the provider a few minutes to review your answers.

To enter waiting room, type the following into your browser: doxy.me/dralban

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Main Concern: Describe the main reason you are seeking treatment currently. What symptoms do you have? Are there any circumstances/events that have contributed to what you are going through?

Medical History:
Specify medical conditions, doctors treating the condition and related medications with dosages. Supplements? Medical cannabis

- Allergies (medications/food, describe reaction):

- Surgeries:

- Concussions (approximate dates, health implications):

Psychiatric History:

- List prior medication trials, approximate dates tried and outcomes:

- List prior therapies, psychological testing, psych med management and providers with approximate dates attended.

- List prior psychiatric hospitalizations, reasons for hospitalization, where hospitalized, and approximate dates:

- History of substance abuse, alcohol abuse/use, smoking/vaping:

Family Psychiatric History:

Please describe your family psychiatric history, including any psych medications they may have tried:

Psychosocial History:
Who is living in your household? What is the family structure (blended, single parent, custody issues...)?

Support system (family, friends, relationship, worship...)

Legal History (prior arrests, DUI, violence):

Academic History (Students):
What grade are you in and what is the name of your school?

Do you have a 504/IEP at school? If so, what kind of accommodations do you have?

Do you work? If so, what kind of job and how many hours?

Employment/Education (Adults):

What is your highest level of education? What is your occupation? Are you retired? If on disability, describe circumstances.

Child Development:
Describe any issues during pregnancy and birth.
Did your child have any delays in speech, fine/gross motor skills, social skills, academics or other?

Symptoms Questions: For young children, parents should answer these questions on the child's behalf, with the child's input.

Describe any issues with falling or staying asleep?

Describe any issues with your energy level currently?

Do you have a history of Depression? If so, describe the types of symptoms you experience when you are depressed.

Have you ever had thoughts about suicide or prior attempts? If so, please explain.

Do you have a history of self-harm (Ex. Cutting)? If so, please describe. When was the last episode?

Have you ever had an episode of at least several days of little to no sleep, high energy and productivity, grandiose ideas, elevated or irritable mood? If so, please describe. During the episode, were there any behaviors that were out of character or high risk (overspending, promiscuity).

Have you had issues with anger management? If so, please describe.

Have you had issues with authority, complying with norms or rules?

Have you ever had psychotic symptoms (hearing voices, seeing things others do not, odd sensations of touch or smell)?

Do you have trouble with motivation? If so, please describe.

Please rate your mood from 0-10, 10=best mood.

Please rate your level of anxiety from 0-10, 10= highest.

Do you have a history of panic attacks or have had any recently? If so, how frequently?

Do you currently or in the past had any physical symptoms of anxiety, such as muscle tension, headaches, nausea or stomach issues? If so, please describe.

Do you currently or in the past had issues with skin picking or hair pulling?

Do you have compulsions to perform certain acts? Would resisting to give in to the compulsions increase your anxiety?

Do you have obsessive thoughts you cannot seem to get out of your mind?

Have you had difficulties with anxiety when it comes to social interactions? If so, please describe. Has it affected school/work performance/participation?

Have you experienced symptoms of feeling on edge, being easily startled, having nightmares, or reliving moments related to a traumatic event? Do avoid situations that trigger these symptoms? If so, please describe.

Describe any issues with your appetite? Have you gained or lost weight? If so, how much and in what time span?

Do you have a history of eating disorders? Have you excessively restricted your calories or used compensatory strategies to control your intake such as vomiting or using laxatives? Have you had issues with overeating or binge eating? Please describe.

Do you have issues with concentration, controlling your impulses or difficulties with hyperactivity/restlessness? If so, please describe.

Is there anything you would like your provider to know before your session?