GRANGER
MEDICAL CLINIC

Michael Connolly, MD

Adult Information Packet

Patient Name: _____ APPOINTMENT DATE: _____

MRN#: _____ DOB: _____

By completing this questionnaire and returning it prior to your appointment, you will help make your evaluation as thorough as possible in our first visit increasing the chance that treatment can begin immediately. If there is a question that you cannot, or do not wish to, answer simply leave it blank.

General Information

Name: _____ Date of birth: _____

Age: _____ Sex: Male Female Occupation: _____

Marital Status: Single Married Separated Divorced Widowed

Who referred you to see Dr. Connolly? _____

Current Problems

Describe the problem(s) for which you are seeking help: _____

_____

_____

Why have you chosen to seek help now? _____

_____

_____

When did your problems begin? _____

_____

_____

What might have caused these problems? _____

_____

_____

Please list any previous psychiatric hospitalizations, residential or day treatment programs (including any alcohol and drug treatment programs):

Date	Location	Diagnosis	Helpful: Yes/No

Please list any current or prior outpatient psychiatrists and/or therapists you have seen:

Medication History

Current psychiatric medications:

Name	Duration	Dose	Response

Previous Psychiatric medications you have tried:

Name and Dose	Duration	Response	Reason for Stopping

Current NON-psychiatric medication including herbals and vitamins:

Name and Dose	Duration	Response	Reason for Stopping

Have you ever attempted suicide? Yes No

If yes, complete the following:

Date	How did you attempt it?	What happened?

Have you ever thought about hurting someone else? Yes No

Symptom Checklist

Please indicate how much trouble you had with each of the following symptoms in the past month:

Symptom	Not at all	A little	A great deal	Extremely
Feeling sad				
Feeling irritable				
Feeling unworthy or a failure				
Feeling guilty				
Loss of interest in most things				
Loss of pleasure in most things				
Difficulty making decisions				
Feeling tired or low in energy				
Loss of appetite				
Loss of weight				
Increase in appetite				
Increase in weight				
Difficulty falling asleep at night				
Waking up during the night				
Waking up too early in the morning				
Sleeping more than usual				
Feeling that this is no hope				
Thoughts of death or suicide				
Feeling anxious				
Worrying				
Feeling tense				
Restlessness				
Headaches or other aches or pains				
Heart beating quickly or strongly without reason				
Chest pains				
Difficulty breathing or feeling unable to get enough air				
Attacks of pain				
Washing your hands over and over				
Irrational fears of certain objects or situations				
Thoughts that distress you that you cannot get rid of				
Checking things repeatedly				
Strange ideas or experiences which other people do not have				
Feeling that someone is giving you a hard time or trying to hurt you				
Hearing things others cannot hear				
Seeing things that others cannot see				

Family History

Father

Is your father still living? Yes No If yes, what is his age? _____

What is/was his occupation? _____

Describe your father's:

Personality: _____

Attitude towards you: _____

Relationship with you when you were a child: _____

_____

Relationship with you now: _____

_____

If deceased: Age at his death: _____ Cause of his death: _____

Mother

Is your mother still living? Yes No If yes, what is her age? _____

What is/was her occupation? _____

Describe your mother's:

Personality: _____

Attitude towards you: _____

Relationship with you when you were a child: _____

_____

Relationship with you now: _____

_____

If deceased: Age at her death: _____ Cause of her death: _____

If your parents divorced, how old were you when this happened? _____

Brothers and Sisters

List your brothers and sisters, including yourself, from the oldest to the youngest:

Name	Age	Sex	Relationship – Close/Distant

Yes **No** Does any member of your family (including aunts, uncles, and grandparents) suffer from depression, anxiety, alcoholism, other substance abuse problems, or any other emotional or mental disorder?

Yes **No** Has any relative attempted suicide?

If you answered yes to either of the last two questions, please give details: _____

_____

_____

Social History

Where were you born and raised?_____

What was your family's financial status growing up?_____

What are your current sources of income?_____

Do you have current financial stresses?_____

What is your current religious preference?_____

Is spirituality important in your life?_____

Developmental History

Are you aware of any difficulties in completing developmental tasks while growing up such as walking, talking or toilet training? Yes No

Check any of the following that occurred during your childhood or adolescence:

Family Problems	_____
Afraid to go to school	_____
Short attention span	_____
Hyperactivity	_____
Anorexia/Bulimia	_____
Truancy	_____
Ran away from home	_____
Legal problems	_____
Alcohol or other drug abuse	_____

Were you abused growing up? ____Not at all ____Emotionally ____Physically ____Sexually

Please list any other traumatic events you have suffered:_____

_____

_____

Did you make friends easily? Yes No

If no, what problems did you have?_____

_____

Did you date during high school? Yes No

List your interests (club, hobbies, etc.) during your teens: _____

_____

_____

_____

Educational/Occupational History

How were your grades in school?_____

Did you graduate from High School? Yes No

List any degrees earned beyond high school:

Degree Major School Year

_____

_____

_____

Have you served in the military? Yes No

List the jobs you've held since completing your education: _____

_____

_____

_____

How long have you had your current job?_____

Does your current job satisfy you? Yes No

If you answered no, please explain:_____

_____

_____

_____

Legal History

Any legal problems past or present? Yes No

If you answered yes, please explain: _____

_____

_____

_____

Interpersonal History

	1st Marriage or Relationship	2nd Marriage or Relationship	3rd Marriage or Relationship
Partner's name			
Age when you married			
Reason it ended			
Number of children			
Length of relationship			

Current Partner: _____

Name: _____ Age: _____

Occupation: _____

Personality: _____

In what areas are you compatible? _____

In what areas are you incompatible? _____

List your children, from oldest to youngest:

Name Age Sex Relationship – Close/Distant

_____

_____

_____

_____

_____

Do any of your children present special problems? Yes No

If you answered yes, please explain: _____

_____

_____

_____

Who provides emotional support for you? _____

How comfortable are you in social situations?

_____ Very comfortable _____ Relatively Comfortable _____ Relatively Uncomfortable

_____ Very Anxious