8550 Cuthills Circle | Lincoln, NE 68526
Phone: 402.476.6060 | Fax: 402.476.6809
alivation.com

Patient Questionnaire-

Patient Name: _____ DOB: ___/___/___ Date: _____

Were you referred here? If yes, by who? _____

What are your current symptoms or concerns? _____

_____

Please list ALL of your current medications and dosages that you are taking as well as any side effects that you are experiencing. _____

_____

Have you seen a psychiatrist, therapist, or counselor in the past? If so, who did you see and when did you see them?

_____

_____

Have you been hospitalized for psychiatric concerns or gone to treatment in the past? If so when and where did you go?

_____

_____

Please list any medications that you have taken in the past and their effects _____

_____

_____

Who is your primary care provider? (i.e. where you go for physical illness), and when was the last time you were seen by them? If none, would you be interested in seeing a primary care provider at Alivation?

_____

Females:

Are you pregnant? Y/N If yes, who is your provider? _____ Are you breastfeeding? Y/N

How many times have you been pregnant? _____ How many births? _____ Do you use a form of birth control?

_____

Please check if you have any of the following chronic health conditions:

☐ Asthma ☐ Seizures ☐ Diabetes ☐ High Blood Pressure ☐ High Cholesterol

☐ Thyroid Problems ☐ Cardiac Problems ☐ Chronic Pain ☐ Other: _____

Please list any surgeries: _____

Are you allergic to any medications, foods, or have any environmental allergies? If so, to what and what kind of reaction? _____

_____

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Is there anyone in your immediate family with a mental illness or substance abuse problem? If so, who and what? Please list any medications that you know they are taking. _____

Where were you born? _____ Where were you raised? _____
How long have you lived at your current address and who lives with you? _____

_____

Are you in school? If so, what grade? _____

What is your highest level of education that you have completed? _____

Do you work? If so, where and what do you do? _____

Do you have a religious or spiritual preference? If so, what is it? _____

What is your family of origin (i.e. who raised you, how many siblings, ect)? _____

_____

Are you currently married? If so, how long? Any previous marriages? _____

Do you have any children? If so, please list age and sex. _____

_____

Do you drink alcohol? If so, how often and how many do you drink? _____

Do you use drugs? If so, what drugs and how often do you use? _____

Do you use any tobacco products? If so, what kind and how much do you use in a day? _____

Do you drink caffeinated beverages (i.e. soda, coffee, tea, or energy drinks)? If so, what kind and how many of each do you drink in a day? _____

Has there been any physical, emotional, or sexual abuse in the past? Y/N _____

Do you have any legal offenses or charges? _____

Has CPS been involved? If so, what is the name of the case worker? _____

Is there any history of disability? _____

Are you your own legal guardian? If not, please list name of guardian. _____

What pharmacy do you use? Would you like to use Alivation Pharmacy?

_____

Any other information that you would like us to know: _____

_____

_____