Steven Kanfer, M.D.
Center for Mental Health
Adult, Child and Adolescent Psychiatry
Board Certified in Psychiatry,
Board Certified in Child and Adolescent Psychiatry

806 W. De Leon St.
Tampa, FL 33606
(813) 250-0224

ADULT PATIENT QUESTIONNAIRE

In order for us to be able to **fully** evaluate you, please/fill out the following questionnaire to the best of your ability. W realize there may be information that you do not remember or have to access to, but please do the best you can. Thank you.

PATIENT IDENTIFICATION

Name: First appt, date:_______

Birth Date : Age: Sex

Social Security #

Address: ______________________________________ City: State: Zip:

Home Phone:( ) Work phone:( )

Which phone number do you prefer to be contacted at?__________________________

Emergency contact (name, relationship and phone number):

REFERRAL SOURCE:

Person or Agency that referred you to Dr. Kanfer

Address : Phone:

Do we have permission to release information to the referring profession when it is appropriate ? Yes No

PRIOR ATTEMPTS TO CORRECT PROBLEMS:

PRIOR PSYCHIATRIC HISTORY

Previous psychiatrist/psychologist/therapist

Any history of psychiatric hospitalizations? If yes, when and how long?

History of suicide attempts? If yes when did it happen and how many times have they attempted suicide?

What past psychiatric medications have been tried and what was the response?

MEDICAL HISTORY
Current medical problems :

Past medical problems:

Other doctors/clinics see regularly:

Any history of head trauma ? (describe)

Every any seizure or seizure like activity ? Any periods of spaciness or confusion ?

Prior hospitalizations(place, cause, date, outcome)

Any history of infections of the brain like encephalitis or meningitis?

Prior abnormal lab tests, X-rays, EEG, etc.

Allergies/drug allergies or drug intolerances (describe)::

Present Height Present Weight:

MEDICATIONS: (please list all current prescription medications, over the counter medications, vitamins and health food supplements).

Name	Strength	How often taken

FAMILY MEDICAL HISTORY (Please include psychiatric illness and learning disabilities in this area)

FAMILY STRESSES (please list current factors that are a source of stress to you)

I ________________________________ agree that I am financially responsible for the services provided to me by Steven Kanfer, M.D. Payment is due at the time services rendered.

___________________________ ____________________

Patient Date