Steven Kanfer, M.D.
Adult, Child and Adolescent Psychiatry
Board Certified in Psychiatry
Board Certified in Child and Adolescent Psychiatry

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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. We realize there may be information that you do not remember or have 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 is your preferred contact number?_____

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 professional 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 suicide attempts?

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

MEDICAL HISTORY
Current medical problems:

Past medical problems:

Other doctors/clinics seen regularly:

Any history of head trauma? (describe)

Ever 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, Xrays, 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