

Decker Student Health Services Center  
Binghamton University  
P.O. Box 6000  
Binghamton, NY 13902-6000  
Phone: 607-777-2221 Fax: 607-777-2881

Student Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

***\*\*All information is kept in your CONFIDENTIAL medical record and will not be released without your consent.***

***Initial Psychiatric Visit Self-Questionnaire***      ***Today's Date*** \_\_\_\_\_

**Current (School) Mailing Address and Phone:** \_\_\_\_\_  
\_\_\_\_\_

**Home (Vacation/Summer) Mailing Address and Phone:**  check if same as above or:  
\_\_\_\_\_  
\_\_\_\_\_

**Current Insurance Coverage: -Name of Company:** \_\_\_\_\_  
**(\*\*Bring Card with you to appointment) Insurance Number:** \_\_\_\_\_

**Primary Care Doctor (Name and location):** \_\_\_\_\_  
**(Phone and Fax Number):** \_\_\_\_\_  
**May we contact your doctor as needed to continue care?**  YES  NO  
\*If yes, please complete release of information attached.

**Do you see a psychiatrist/therapist/counselor at school and/or at home?**  YES  NO  
**Name, Location, Phone and Fax Number (if not local):** \_\_\_\_\_  
\_\_\_\_\_  
\*If yes, please complete a release of information attached.

**Do you want you parents and/or significant other to know about your mental health care?**  YES  NO    **Names:** \_\_\_\_\_  
\*If yes, please complete a release of information to allow us to communicate with them if they call.

**History of Current Problems**

-Describe, in your own words, what issues bring you in for help.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**Medical History**

-Do you have any health problems or complaints? (Please list any conditions)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

-What was the first day of your last menstrual period? \_\_\_\_\_

-Are you currently taking any medications? (Please list all meds and doses)

\_\_\_\_\_  
\_\_\_\_\_

-Do you have any **allergies** to any medication, food, or environmental substances?  
(Please list all and the reaction you have) \_\_\_\_\_

\_\_\_\_\_

**Family and Social History**

-What is your city, state and country of birth? \_\_\_\_\_

-What is your primary language? \_\_\_\_\_

-Are your parents married, separated or divorced? \_\_\_\_\_

-Age of mother (or age and cause of death) \_\_\_\_\_

-Any medical or mental health problems with mom? \_\_\_\_\_

-Mother's occupation: \_\_\_\_\_

-Age of father (or age and cause of death) \_\_\_\_\_

-Any medical or mental health problems with dad? \_\_\_\_\_

-Father's occupation: \_\_\_\_\_

-Do you have any siblings? List age and sex of each.

\_\_\_\_\_

-Do your siblings have any significant medical, mental health or substance abuse problems? \_\_\_\_\_

-Does anyone else in your immediate or extended family have a history of mental health or substance/alcohol abuse issues? \_\_\_\_\_

\_\_\_\_\_

-Is there any family history of suicides or psychosis? \_\_\_\_\_

-What is your family's religious affiliation? \_\_\_\_\_

-What are your religious beliefs? \_\_\_\_\_

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-Describe the quality of your current domestic situation at home.  
(circle the number that best describes your situation)  
**Not happy at all** 1 2 3 4 5 6 7 **Very happy**

-Describe your living situation (on or off campus. roommates?)  
\_\_\_\_\_

-Describe the quality of your current domestic situation at school.  
(circle the number that best describes your situation)  
**Not happy at all** 1 2 3 4 5 6 7 **Very happy**

-How are you doing academically? Have you ever needed to take an incomplete or withdrawal due to mental health concerns? \_\_\_\_\_

-What is your occupation outside of being a student? \_\_\_\_\_

**Background Information**

-What year are you in college? \_\_\_\_\_

-What is your field of study/major? \_\_\_\_\_

-What do you hope to do after graduation? \_\_\_\_\_

**Sex:**  Female  Male **Ethnicity:** \_\_\_\_\_ **Marital Status:** \_\_\_\_\_

**Sexual Orientation:** \_\_\_\_\_

**Substance Use History**

-Do you drink alcohol?  no  yes # drinks/week: \_\_\_\_\_

If yes: Have you ever felt you should cut down on your drinking?  yes  no

Have people annoyed you by criticizing your drinking?  yes  no

Have you ever felt bad or guilty about your drinking?  yes  no

Have you ever had a drink in the morning to steady your nerves or get rid of hangover symptoms (eye-opener?)  yes  no

-Do you smoke cigarettes or use other tobacco products?  no  yes # per day \_\_\_\_\_

-Please check the following drugs that you have used in the past or currently use:

Cannabis:  Hashish  marijuana  \_\_\_\_\_

Depressants:  Barbiturates  Benzodiazepines (Valium, Xanax, Ativan)  \_\_\_\_\_

Hallucinogens:  LSD (acid)  mescaline  PCP  mushrooms  \_\_\_\_\_

Stimulants:  amphetamines (Ritalin, Concerta, Adderall, Vyvanse, etc)  ecstasy

cocaine  caffeine  guarana  pseudoephedrine  DXM

Narcotics:  codeine  heroine  hydrocodone, oxycodone (Vicodin, oxy)

morphine  opium  Darvocet  (other) \_\_\_\_\_

Any other drugs, herbs, vitamins or supplements: \_\_\_\_\_

Describe the frequency of use and the reason for use of the above drugs: \_\_\_\_\_

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**Lifestyle Habits**

-Do you exercise? YES NO -if yes, what type and how many times per week?

\_\_\_\_\_  
-Are you involved in any clubs, activities or sports teams? If so, list: \_\_\_\_\_

\_\_\_\_\_  
- How many times a day do you eat? \_\_\_\_\_

-Do you have any special type of diet? \_\_\_\_\_

-Are there any foods you do not eat? YES NO -If yes, what foods to you not eat and why? \_\_\_\_\_

-Please list the meals you have eaten, the foods and liquids you have consumed over the last 24 hours: \_\_\_\_\_

\_\_\_\_\_  
- Do you have any concerns about your weight? YES NO -if yes, explain \_\_\_\_\_

\_\_\_\_\_  
- How many hours do you sleep during a 24 hour period? \_\_\_\_\_

- Do you have any trouble falling asleep? \_\_\_\_\_

- Do you have any trouble staying asleep? \_\_\_\_\_

- What is you normal bed and wake times? \_\_\_\_\_

- What do you do for fun? \_\_\_\_\_

**Counseling History**

-Have you ever been in therapy, substance abuse counseling, or taken psychiatric medication in the past? If so, please give details of medications tried, responses and side effects, and reasons for counseling. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

-Have you ever been hospitalized for mental health or substance abuse issues? If yes, when, why and how long were you inpatient?

\_\_\_\_\_  
\_\_\_\_\_

-Any past or present suicidal thoughts, plans or attempts? YES NO  
Explain \_\_\_\_\_

\_\_\_\_\_  
-Any past or present thoughts about harming someone else? YES NO  
Explain \_\_\_\_\_

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*-Did any of the following events occur during your childhood or adolescence?*

- Physical Abuse       Verbal Abuse       Witnessing violence  
 Teasing/Bullying       Sexual abuse or rape       Medical Problems  
 Rigid religious way of life       Trauma (fire, crime victim, natural disaster, etc)  
 Drug/alcohol abuse       Medical Problems       Extreme Parental Control/Pressure

*-In the past and/or currently, have you ever experienced and problems with any of the following symptoms or behaviors: (Check all that apply)*

- self-harm (cutting, burning, overdosing)       suicidal thoughts, plans or attempts  
 Using illegal or prescription drugs       Excessive use of alcohol       blackouts  
 Memory disturbances       Self-induced vomiting       Laxative Abuse  
 Odd or irrational behavior       Depression       Nervous Tics  
 Impulsiveness       obsessions/ compulsions/rituals       restrictive eating  
 Aggressive or violent behavior       legal problems       anxious avoidance  
 Seriously risky behavior       Promiscuity       weight loss  
 Inability to sleep for more than 48 hours straight       Insomnia/sleep disturbance  
 Loss of interest in sex       Concerns about sexual identity  
 Hallucinations (hearing voices, seeing or hearing things others do not see)

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**\*\*\* Thank you, all this information will help us to gain a clear picture of your background. Your first appointment will involve reviewing and clarifying this information and will last 45-60 minutes. Please feel free to bring in any questions or concerns you have to any visit with us.**