Mitchel G. Katz, MD
New Patient Questionnaire (Adult)

Patient Name: _____ Age: ___ Today's Date: _____

Person completing this form: _____

How did you hear about Dr. Katz?_____

Do you have a primary care physician?_____

Please describe the problems for which help is needed at this time or questions you wish answered (may use supplemental sheets):

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Current Employment Information:

Name of employer: _____

Occupation/type of work:_____

How long at this job:_____

Please describe employment history after leaving school:

Educational History:

High school attended/date of graduation:_____

Technical/vocational school(s) attended/dates:_____

College(s) attended/dates/degrees awarded:

Grades repeated: _____Grades skipped:_____ Suspensions/expulsions _____if yes supply details on supplemental page

Any known learning disabilities? ____No ____Yes (explain below)
Did you attend "regular" classes in elementary and middle school? ____Yes ____No (explain below)
Did any school ever perform any type of evaluation on you? ____No ____Yes (explain below)

Mental Health History:

Are you currently, or at any time in the past, been seen by any type of counselor, therapist, psychologist, psychiatrist, or other mental-health professional? ___No ____Yes (if yes, please provide details including names, dates, issues dealt with, and reason for leaving/stopping)

Medical History:

Do you take any (non-psychiatric) medications on a regular basis? ____No ____Yes

Do you have any chronic medical illnesses? ____No ____Yes

Have you had any significant head trauma (including concussions)? ____No ___Yes

Have you ever been seriously ill? ____No ____Yes

Do you use tobacco, alcohol, or illicit drugs? ___No ____Yes

(if "Yes" to any of the above, please provide details below)

Psychiatric Medication History:

Have you ever taken psychiatric medications? ____ No If no, please turn to page 5 and continue
____ Yes If yes, please complete the following.

	Medication	Medication
Drug Name		
Given by Whom		
When Started		
When Stopped		
For What Problems		
Dose		
Benefits		
Side Effects		
Results		

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Social History:

Current living situation:_____

Current marital status:_____

Martial history:_____

Children? Ages?_____

Any family history of ADHD, learning issues, mental illness? _____No ____Yes (describe below)

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Is there anything else you would like us to know before we meet together?

Are there any questions that should have been asked but were not?

Signature _____ Date _____

Please feel free to use additional sheets of paper to supply additional information and/or details