Berkeley Therapy Institute, A Nonprofit Organization
1749 Martin Luther King Jr Way, Berkeley CA 94709, (510) 841-8484 info@bti.org

PATIENT HEALTH QUESTIONNAIRE

Please answer the following questions as accurately as you can. If you run out of room you may use the back of the page. Your doctor needs this information in order to provide the best possible care.

PATIENT NAME _____

Who is your primary care physician?_____
Do you want us to send a report /communicate with that person? Yes_____ No _____

When was your last physical exam?_____

When did you last have laboratory tests / blood tests? _____ Was anything abnormal?
List here:_____

Have you ever had any of the following?

	YES	NO	details
Headaches			
Seizures or convulsions			
Visual or hearing problems			
Head injury / loss of consciousness			
Stroke			
Dizziness, fainting			
Respiratory problems or trouble breathing			
Heart disease			
Liver or gall bladder problems			
Kidney problems			
Problems with urination			
Problems with sexual function			
Gastrointestinal problems / diarrhea / constipation			
Diabetes / blood sugar problems			
Skin problems			
Allergies			
Surgical procedures			
Cancer			
Blood transfusion			
Any other (please describe)			

Are you allergic to any medication, drug, or substance? Yes_____ No _____

Which one(s)_____

Have you ever had an adverse reaction to any medication, drug, or substance? Yes___ No ____

Have you ever taken a street drug or a drug that was prescribed for someone else (not for you)?
Yes_____ No_____

Have you ever been told you have or been diagnosed with or treated for drug abuse, drug dependency, or alcoholism? Put this down here even if you believe the diagnosis was wrong.
Yes ____ No_____

List all the prescription drugs (psychiatric and non-psychiatric) that you are taking:

Drug with dose	Who prescribed it?	When was it started?	Purpose	Side Effects? Benefits?

List all non-prescription drugs, herbs, vitamins, and supplements that you sometimes use:

Name of drug or herb with dose or amount	Purpose / when do you take it?	Effects both positive and negative

signature _____ date _____

PRINT NAME _____