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Mind Body Institute of Chester County

New Patient Clinical Questionnaire:

Patient's Name: Date of Birth:

1-Reason for evaluation / consultation, and symptoms (with duration):

2-History of psychiatric problems, diagnoses, and treatment:

3-History of alcohol, and drug abuse, including date of last use:

4-Past medical history (with duration):

5-Drug allergies:

6-Smoking (i.e. current smoker-how many cigarettes/day; or former smoker; or never smoked):

7-Family history of emotional and mental illness:

8- List of all current medicines, including mg strength, frequency of dose, purpose and efficacy:

9-Expected outcome of the treatment here:

10-Pharmacy's name, address, and phone number:

Patient's signature: ___________________________ Date: __________

Guardian's Signature: _________________________ Date: __________

Doctor's signature: ___________________________ Date: __________