Anjum Irfan, MD. PC
Mind Body Institute of Chester County

New Patient Clinical Questionnaire

Patient Name:_____Date of birth: _____

1. Who referred you to our practice?

2. Reason for evaluation/consultation and symptoms (with duration):

3. History of psychiatric problems, diagnoses, and treatment:

4. Any History of Psychiatric Hospitalization or Rehab Admissions:

5. What Rx medication have you tried for your Mental//Emotional Health? Please include name of medication, mg, and how long you were on it.

6. History of alcohol and drug abuse, including date of last use:

7. Past Medical History (with duration):

Diabetes Mellitus	Y/N	Brain Injury	Y/N		
High Blood Pressure	Y/N	Kidney Disease	Y/N		
Heart Disease	Y/N	Liver Disease	Y/N		
Lung Disease	Y/N	GI Disease	Y/N		
Seizure	Y/N	Chronic Pain	Y/N		
Stroke	Y/N	Musculoskeletal issues	Y/N		

8. Drug Allergies:

9. Smoking (i.e current smoker, how many cigarettes per day; former smoker; never smoked) This includes Cigarettes/cigar smoke, Vape/or chew nicotine or tobacco, any use of cannabis or medical marijuana.

10. Family History of Emotional and Mental Illness? This includes mother, father, siblings, children, aunts, uncles, grandparents.

11. List all current medications, including mg, frequency of dose, purpose, and efficacy:

12. Expected outcome of treatment here:
    1. Looking for a new psychiatrist?

    2. Looking for Rx medications for Mental Health issues?

    3. Looking for Psychotherapy or Counseling?

    4. Other?

Patient's signature: _____ Date: _____

Guardian's signature: _____ Date:_____

Name of person who completed this form: _____

Doctor's signature: __ _____ Date:_____