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History Questionnaire

The purpose of this questionnaire is to obtain a comprehensive picture of your difficulties and circumstances. By completing these questions as fully and accurately as you can, you will save both time and expense. You are requested to answer these routine questions on your own time instead of using up your actual consulting time.

Please Note: If you do not desire to answer any question, merely write, "Do not care to answer."

Date: _____

1. General

Name Of Patient: _____

Address: _____

Telephone #: _____

Age: _____ Height: _____ Weight: _____ Date Of Birth: _____

Place Of Birth: _____

Do you live in a house, apartment, room, hotel, etc.? _____

Marital Status: _____

Current Occupation(s): _____

2. Life History

It would be very helpful if you could write, as best you can, a narrative history of your difficulties including specific dates. This should include the approximate date your problems first started, the major troubling symptoms and difficulties, and your response to them. Please include the various forms of treatment received. You can be as detailed or as terse as you prefer.

Whom have you previously consulted about your problems?
Please list and give complete information below:

Name and Profession	Type Of Treatment: Psychotherapy, Medication, Behavior Therapy?	Dates of first consultation or treatment	How long did treatment continue (please state if still being treated)

Previous Hospitalization for Any Reason

Hospital and Doctor's Name	Dates	Reason For Hospitalization

Below, please list, to the best of your knowledge, the medications you have taken for emotional or behavioral problems in the past, either by prescription or on your own,

including those you are now taking. If you don't remember, check with your doctor or pharmacy.

Dates: From and To	Medication	Highest Dosage Taken	Results – positive and negative

List all medical illnesses or health problems you have had at any time.

Describe Illness or Health Problems	Your age at the time	Treatment Received Including Medications
List any surgical operations	Your Age	Describe Operations
List any accidents	Your Age	Describe accidents

4. Do you currently use alcohol and/or drugs? Please give details.

5. Have you ever used alcohol and or drugs in the past more than you do now? If so, at what age, and extent of maximum use.

6. Has any member of your family (parents, siblings, grandparents, aunts, uncles, cousins) ever had a problem with alcoholism, problem drinking, and/or other drugs? If so, please describe:

List Family Member	Describe Problem	Describe any treatment or hospitalization/rehab for this problem

Has any member of your family ever had any other neurological, mental or emotional problem (for example epilepsy, depression, bipolar disorder, or “nervous breakdown”)?

List Family Member	Describe Problem	Describe any treatment or hospitalization for this problem

