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### History Questionnaire

*\*Please note, this form is easier to complete typed as a Word document. Please elaborate whenever relevant, if possible.\**

##### Client Name:

##### Date of Birth:

##### The purpose of this questionnaire is to obtain a comprehensive summary of your difficulties and circumstances prior to meeting in person. Case records are strictly confidential. If you do not desire to answer any question, simply leave it blank. To begin, it would be very helpful if you could write a narrative history of your difficulties:

##### What are your goals for this evaluation and/or treatment?:

##### If you are able, please indicate whether you exhibited any of the following during the **first 12 months of life**; please elaborate when relevant:

* Difficulty getting to sleep:
* Difficulty with feeding:
* Colicky behaviors/symptoms:
* Difficulty being put on a schedule:
* Difficulty with alertness:
* Cheerful demeanor:
* Sociable behavior:
* Affectionate behavior:
* Easy to comfort:
* Difficulty keeping busy:
* Overactivity, being in constant motion:
* Stubborn, challenging nature:

##### If you are able, please indicate whether you achieved the following **developmental milestones** by the listed age; please elaborate when relevant:

* Sat-up before 9 mo:
* Walked without assistance before 18 mo:
* Spoke first words before 18 mo:
* Joined words together before 2 ½ yo:
* Stopped wetting bed before age 4:
* Stopped soiling pants by age 4:

Please indicate whether you experienced any of the following in **early childhood**; please elaborate when relevant:

* Recurrent, meaningless body movements (e.g., flapping, rolling, rocking, slapping self):
* Injured self on purpose/cut self with sharp instrument:
* Talked excessively or very fast speech:
* Yelled or screamed inappropriately; excessive temper tantrums (in frequency and/or intensity):
* Odd, eccentric behavior:
* Fixed facial expression; lack of emotional responsiveness; showed few social reactions:
* Repetitive speech, words, phrases:
* Resisted physical contact:
* Isolated self, preferred to be alone:
* Difficult to reach, contact or get through to; did not seem/appear to listen when spoken to directly:
* Did not try to communicate by words or gestures:
* Night terrors/nightmares:

##### Please indicate whether you have experienced any of the following symptoms/experiences of **anxiety or worry**; please elaborate when relevant:

* Marked or specific fear of closed spaces, animals, heights, animals, crowded spaces, other:
* Afraid to try new things for fear of making mistakes:
* Blame self for problems, feels guilty:
* Excessive worry or anxiety; apprehensive anticipation:
* Excessive worry/fear about being liked (e.g., feel nervous when one is with other people and/or has to do something while being watched; fear of speaking in public or in front of others; fear of talking to people of authority or strangers; fear of being embarrassed, criticized, humiliated or perceived as worthless/inferior; feeling like one couldn’t do anything well or that one is not as good or as smart as other people, fear of social gatherings; when one is with others, experience blushing, palpitations, trembling/shaking, sweating):
* Excessive worry about harm befalling caregivers or excessive distress when alone and/or separated from family/loved ones:
* Extreme clinging behavior; follow loved ones like a shadow:
* Repeated complaints of physical symptoms when separated from loved ones/caregivers, etc:
* Other symptoms:

Please indicate whether you have experienced any of the following symptoms/experiences of **panic**; please elaborate when relevant:

* Accelerated heart rate:
* Pounding heart:
* Heart palpitations:
* Sweating:
* Shortness of breath or difficulty breathing:
* Chest pain or discomfort:
* Sensation of choking:
* Trembling or shaking:
* Nausea, abdominal pain/distress/discomfort:
* Dizziness, unsteadiness, lightheadedness, or feeling faint:
* Chills or heat sensations:
* Tingling sensations:
* Derealization (feeling like life is not real or is like a movie):
* Depersonalization (feeling like one is not real or is floating above or beside oneself):
* Fear of losing control or “going crazy”:
* Fear of dying:
* Other symptoms:
* Persistent concern or worry about additional panic attacks or their consequences:
* Significant, maladaptive change in behavior related to panic attacks (or avoidance of potential triggers of panic attacks):

##### Please indicate whether you have experienced any of the following symptoms/experiences related to **trauma**; please elaborate when relevant:

* Direct experience, witnessing, or learning of traumatic event(s):
* Repeated or extreme exposure to aversive details of the traumatic event(s):
* Recurrent, involuntary, intrusive, distressing memories of the traumatic event(s):
* Recurrent distressing dreams related to the traumatic event(s):
* Dissociative reactions (e.g. flashbacks):
* Intense or prolonged psychological distress at exposure to internal or external cues related to traumatic event(s):
* Marked physical reactions to internal or external trauma-related cues; hypervigilance:
* Persistent avoidance of stimuli associated with the traumatic event(s):
* Difficulty falling or staying asleep, related directly or indirectly to the traumatic event(s):
* Negative changes in cognition and mood (e.g. memory), related directly or indirectly to the traumatic event(s):
* Other symptoms:

Please indicate whether you have experienced any of the following symptoms/experiences related to **obsessional thoughts and/or compulsive rituals/behaviors**; please elaborate when relevant:

* Obsessional thoughts about germs, contamination, dirtiness, and/or illness:
* Obsessional thoughts about religious issues/concerns (beyond regular religious practice):
* Obsessional thoughts about safety and/or harm to self or others:
* Obsessional thoughts about unwanted acts/images of violence or aggression:
* Obsessional/unwanted sexual thoughts/imagery:
* Obsessional thoughts about symmetry and/or order:
* Obsessional thoughts about numbers:
* Obsessional thoughts about exactness:
* Compulsive checking:
* Compulsive washing/cleaning:
* Compulsive counting:
* Compulsive ordering/arranging:
* Compulsive repeating of routines:
* Compulsive hoarding:
* Compulsive reassurance seeking:
* Other symptoms:
* How much time per day do obsessions and compulsions take up?:
* Do these obsessive or compulsive behaviors cause distress and/or impairment?:

Please indicate whether you have experienced symptoms/experiences related to **restrictive eating, overexercising to lose weight, binge eating, purging through vomiting, excessive use of diuretics/laxatives, or other symptoms of eating disorders (anorexia nervosa, bulimia nervosa, or mixed eating disorder)**; please elaborate:

Please indicate whether you have experienced any of the following symptoms/experiences related to **hypomanic or manic** **mood**; please elaborate when relevant:

* Unusually elevated, elated, silly, giddy, goofy or irritable/agitated/argumentative mood for most hours of the day for 4 or more consecutive days:
* Much more active or do many more things than usual for most hours of the day for 4 or more consecutive days:
* Much more social than usual and/or more interested in sex than usual for 4 or more consecutive days:
* Much more talkative and/or speak much faster than normal for 4 or more consecutive days:
* Too many ideas at once, ideas and/or thoughts that are unusually fast for 4 or more consecutive days:
* Exaggerated ideas about self or abilities; more self-confident than usual for 4 or more consecutive days:
* Tell tall tales and/or embellish/exaggerate more than usual for 4 or more consecutive days:
* Experienced notable higher libido or impulsive sexual behavior as an adult or displayed precocious sexual curiosity or behaviors (e.g., openly touched self or others’ private parts) when a child for 4 or more consecutive days:
* Do things or take risks that are unusual for you or that other people might have thought were excessive, foolish or risky; spend money in a way that is unusual for you and that got you or your family in trouble for 4 or more consecutive days:

Please indicate whether you have experienced any of the following symptoms/experiences related to **depression**; please elaborate when relevant:

* Depressed, blue, sad and/or irritable mood for an extended period of time:
* Feel bored, like nothing is pleasurable/fun, not interested in anything for an extended period of time:
* Periods of low energy or withdraw for an extended period of time:
* Feel like you’re being punished for an extended period of time:
* Feel guilty/blame self for an extended period of time:
* Get less or no satisfaction from things/people for an extended period of time:
* Less or no interest, pleasure, and/or functioning in sexual activity for an extended period of time:
* Cry more than usual or for no reason for an extended period of time:
* Periods of self-loathing, self-disgust, feelings of being a failure, feelings of disappointment in self for an extended period of time:
* Less appetite or loss of appetite and/or decreased weight for an extended period of time:
* Carbohydrate craving or increased appetite and/or weight gain for an extended period of time:
* Difficulty falling or staying asleep for an extended period of time:
* Sleeping more than normal/too much for an extended period of time:
* Wake up feeling like body is a lead pipe, difficult to move/get out of bed for an extended period of time:
* More intense interpersonal/rejection sensitivity for an extended period of time:
* Feel physically slowed down, like body is stuck in mud for an extended period of time:
* Have more difficulties making decisions than usual for an extended period of time:
* Feel the future looks hopeless for an extended period of time:
* Other symptoms:
* Have symptoms of depression or other mood symptoms above interfered with or caused difficulties in your life or in your quality of life?:
* Is mood affected by the season of the year?:
* If relevant, is mood affected by menstrual cycle?:

**Suicidal thoughts:**

* Have you experienced suicidal thoughts or thoughts about death, dying, or about people who had died or about being dead yourself:
* Have you ever attempted suicide:
* Have you hurt yourself physically in any way without suicidal intent (e.g., cut yourself, burned yourself, punched a wall, banged your head):

Please indicate whether you have experienced any of the following symptoms/experiences of **inattention/distractibility, impulsivity, and/or motor activity**; please elaborate when relevant:

* Difficulty paying attention to details; make careless mistakes, especially with boring/difficult work; start projects or tasks without reading:
* Difficulty maintaining attention on what needs to be done, especially in boring or repetitive work:
* Difficulty following through when given directions; fail to finish activities (not due to refusal or failure to understand); difficulties with wrapping up the final details of a project, once the challenging parts have been done:
* Difficulty organizing tasks and activities; trouble doing things in proper order:
* Avoid, dislike, or do not want to start tasks that require ongoing mental effort:
* Difficulty losing things necessary for tasks or activities (toys, assignments, pencils, or books):
* Easily distracted by noises or other stimuli/difficulty concentrating even if people are speaking directly to you:
* Forgetful in daily activities; poor follow-through on promises:
* Fidget with hands or feet or squirm in seat; feel restless:
* Leave seat when remaining seated is expected, as in class, meetings:
* Difficulty stopping activities or behaviors when you should do so:
* Difficulty playing quietly; difficulty staying quiet in movies:
* Make decisions impulsively, blurt out answers before questions have been completed:
* Difficulty waiting your turn:
* Interrupt or intrude on others’ conversations and/or activities, finish others’ sentences; interrupt others when they’re busy:
* Difficulty wrapping up the final details of a project, once the challenging parts have been done:
* Difficulty remembering appointments or obligations:
* Difficulty unwinding and relaxing when you have time to yourself:
* Feel you are overly active and compelled to do things, like you were driven by a motor:
* Talk too much in social situations:
* When in a conversation, you often finish the sentences of the people you are talking to, before they can finish them themselves:

Please indicate whether you have experienced any of the following symptoms/experiences of **oppositional or defiant behavior or conduct problems**; please elaborate when relevant:

* Argue with adults; excessively confrontational:
* Actively defy or refuse to go along with requests or rules of adults in positions of authority or power:
* Deliberately annoy others:
* Blame others for your mistakes or misbehaviors:
* Are touchy or easily annoyed by others:
* Are angry or resentful:
* Are spiteful and want to get even:
* Bully, threaten, or intimidate others:
* Start physical fights:
* Lie to get out of trouble or to avoid obligations (e.g., “cons” others):
* Skip school or work without notice:
* Are physically cruel to others:
* Have stolen things that have value:
* Deliberately destroy others’ property:
* Have used a weapon that can cause serious harm (bat, knife, brick, gun):
* Are physically cruel to animals:
* Have deliberately set fires to cause damage:
* Have broken into someone else’s home, business, or car:
* Have stayed out at night without permission as a child:
* Have run away from home overnight as a child:
* Drive with excessive speeds; high number of traffic tickets or traffic accidents; high insurance rates:
* Have forced someone into sexual activity:

##### Please indicate whether you have experienced any of the following **sensory/perceptual experiences**; please elaborate when relevant:

* Auditory, visual, or tactile experiences that others do not or cannot experience:
* Feelings that one is being followed or targeted:
* Feelings that someone is inserting or withdrawing thoughts from your mind:
* Feelings that messages on TV or media are referring to you:
* Feelings that your thoughts are being broadcast to others:
* Feelings that you have special powers that others do not or cannot have:
* Any other unusual feelings or experiences:

##### Do you have **thoughts or urges to harm others**? If so, please elaborate:

Please indicate whether you have experienced any of the following **neuropsychological symptoms/problems;** please elaborate when relevant:

* Learning disorders:
* Sensory processing, sensory integration issues:
* Speech/language problems (expressive and/or receptive):
* Short term memory, processing speed issues:
* Coordination problems:
* Gross or fine motor control issues:
* Extreme sensitivity to textures of clothes, labels, and tightness of fit of socks or shoes:
* Complain of body temperature extremes or feeling hot despite neutral ambient temperature:
* Difficulties in reading, writing, mathematics:
* Other neuropsychological, neurological, or sensory/motor/coordination issues:

##### **School history and performance**:

* Ever skipped a grade or held back in school or had to repeat a year?:
* Ever been suspended or expelled from school?:
* Ever been in special education classes?:
* Finished High School? Where? And what was your GPA?:
* Started and finished college? Where? What is/was your GPA? What was your major? Any academic problems during that time?:
* Any graduate school/post-graduate training? Where? Any problems during that time?:
* What are/were your academic strengths and weaknesses?:

**Current/past psychiatric/psychological treatment**: with whom have you previously consulted about your difficulties?:

* **Psychiatrists**; please list the names and dates of treatment of any psychiatrists with whom you've worked:
* **Psychotherapists**; please list the names and dates of treatment of any psychotherapists with whom you've worked:
* **Neurologists**; please list the names and dates of treatment of any neurologists with whom you've worked:
* **Other clinicians**; please list the names and dates of treatment of other clinicians with whom you've worked:

Please list all **medications you are taking or have taken for emotional, psychiatric, or behavioral difficulties, including over-the-counter and herbal/alternative homeopathic supplements**. Please list doses, time periods during which medication(s) or supplement(s) have been used, and any positive or negative effects:

##### Please list all previous **psychiatric hospitalizations**, including name(s) of hospital(s), dates of hospitalization(s), circumstances surrounding hospitalization(s), and notable clinical/treatment issues during hospital stay(s):

##### Please list all **non-psychiatric medications you are taking, including over-the-counter and herbal/alternative homeopathic supplements**; please include doses:

##### If taking prescription medication for non-psychiatric reasons currently, **who is your prescribing MD**? Please include type of MD, name and phone number:

Any allergies to medications?:

Please indicate whether you have experienced any of the following **physical symptoms/problems/medical disorders**; please elaborate when relevant:

* Headache, migraines:
* Nausea, vomiting, stomach aches, gastritis, esophagitis:
* Diarrhea, irritable bowel:
* Endocrine/hormone-related problems:
* Head injury, concussion, loss of consciousness:
* Shortness of breath, chest pain, chest tightness, or formal asthma:
* Chronic pain:
* High blood pressure/hypertension, heart attack/myocardial infarction, heart valve problems:
* Bone or joint problems:
* Seizures/epilepsy:
* Kidney-related issues, urinary tract problems:
* Chronic fatigue, mononucleosis/EBV, fibromyalgia:
* Dizziness, vertigo, unsteadiness, balance problems, coordination problems:
* Numbness and tingling:
* Vocal or muscle tics (recurrent stereotyped movements or vocalizations):
* Faintness/fainting:
* Diabetes:
* Arthritis:
* Thyroid issues:
* Cancer:
* Autoimmune disorder(s):
* Broken bones:
* Severe cuts requiring stitches:
* Lead poisoning:
* Chronic ear infections (and whether required tubes):
* Hearing difficulties:
* Eye or vision problems:
* Bladder or bowel control problems:
* Rashes/skin issues:
* Exposure to tics/history of Lyme disease:
* Repeated strep/bacterial infections:
* Sexually transmitted diseases (e.g., herpes, HPV, HIV, syphilis, gonorrhea, etc):
* Abnormal muscle movements:
* Liver disease, hepatitis (A/B/C):
* Oral/dental problems:
* Bleeding/bruising issues:
* Any other physical/medical problems/symptoms/issues/complaints?:

Describe any **surgical operations, procedures, or medical hospitalizations**:

**Menstrual history**, if applicable:

* Age at first period?:
* Are periods regular?:
* How painful/uncomfortable are the premenstrual symptoms (PMS) in the 2-4 day prior to one's period?:
* Are psychiatric symptoms worse or different in the 7-10 days prior to one's period?:
* Are there other changes in psychiatric symptoms that correlate with the menstrual period?:

Please detail any current and past **alcohol and drug use**, amount and duration of use, any clinical/medical/legal problems associated with use, and any treatment associated with use, if applicable; please elaborate when relevant:

* Alcohol:
* Cigarettes/nicotine:
* Marijuana/THC/synthetic cannabinoids:
* Benzodiazepines (e.g., Xanax (alprazolam)):
* Opioids (e.g., oxycodone):
* Stimulants (e.g., amphetamine, cocaine):
* Inhalants:
* Bath salts:
* Psychedelic substances (e.g., LSD):
* Ecstasy/Molly/MDMA:
* Other recreational substances:

**Family history, psychiatric**: has any member of the extended multigenerational family ever had psychiatric, learning, behavioral/conduct, or alcohol/substance use problems; any suicide attempts, deaths by suicide, notable legal problems, or anything unusual? Please list family member, problem/disorder, and any treatment (including hospitalization(s)) for such problems:

##### **Family history, medical**: has any member of the extended multigenerational family had medical problems? **Has anyone died before the age of 40 from cardiovascular disease/disorders**? Please list family member, problem/disorder, and any treatment(s) for such problems:

If able, please describe your **mother's pregnancy, your delivery, and your early post-delivery medical course**; please elaborate when relevant:

* Age of mother at birth:
* Age of father at birth:
* Number of full term pregnancies:
* Number of miscarriages:
* Number of therapeutic terminations/abortions:
* Was pregnancy planned?:
* Duration of pregnancy:
* Bleeding during pregnancy?:
* High blood pressure during pregnancy?:
* Excessive nausea/vomiting during pregnancy?:
* Toxemia/preeclampsia during pregnancy?:
* Medications during pregnancy?:
* Swelling of ankles during pregnancy?:
* Kidney infection/disease during pregnancy?:
* Anemia during pregnancy?:
* Diabetes during pregnancy?:
* Recreational drug or alcohol use during pregnancy?:
* Rh incompatibility during pregnancy?:
* Other issues, problems, stresses/traumas, disorders during pregnancy?:
* Was delivery by caesarian section? Any complications?:
* Was delivery by forceps? Any complications?:
* Was there prolonged labor?:
* Was there meconium staining?:
* What were the Apgar scores?:
* Following delivery, was there any difficulty breathing? Was oxygen required? Any problems with pneumonia or asthma as an infant?:
* Following delivery, were there any neurologic issues/seizure(s)/meningitis as an infant?:
* Following delivery, were there any other infections as an infant?:
* Were there any birth defects?:
* Were there any other issues in pregnancy or delivery or in early post-delivery medical care?:
* Breast-fed as an infant? If so, how long?:

**Firearms/guns**; please elaborate when relevant:

* Do you own or have access to firearm(s)/gun(s)/weapon(s)?:
* Is firearm(s)/gun(s) stored in a locked box?:
* Do you own or have access to ammunition?:
* Is ammunition stored separately from firearm(s)/gun(s) in a locked box?:
* If applicable, please list any other safety measures deployed:

##### As part of your regular eating habits, do you frequently ingest **grapefruits, grapefruit juice, or brussels sprouts**? These foods can affect the metabolism of medications. Any other unusual eating/dietary habits?:

**Personal** data:

* Interests, hobbies, activities, sports:
* Ever bullied verbally or physically?:
* Make/keep friends easily?:
* How would you describe your gender?:
* How would you describe your sexual orientation?:
* Sexually active? Using protection?:
* Age when started working:
* Jobs held (in chronological order) and how performed in them:
* If present, describe mother's personality and how you and your mother relate/related with each other:
* If present, describe your father's or other parent/step-parent's personality and how you and they relate/related with each other:
* Ever separated in youth from one or both parents for an extended period of time (aside from vacation or camp)? Give age at time of separation:
* If you have a step-parent, give your age when parent remarried:
* If not brought up entirely by parents, who brought you up and when:
* In what ways were you disciplined by parents?:
* Give an impression of the home atmosphere in your youth:
* Describe your religious upbringing/training:
* Who are the most important people in your life?:
* Describe your current living situation. Do you live alone, with others, with family, etc:

##### What else would you like me to know?: