Date of Completion: ________________

Outreach Services of Indiana

PSYCHIATRIC CONSULTATION QUESTIONNAIRE

Client's Name: ___________________ **Date:**_____________ **Date of Birth:** ________________
Male _______ **Female**______ **Height:** ______ **Weight:** _______ **Goal Weight**: ________________
Date of admission to current residential setting: __________________
Guardian: *(Complete if client has a legal guardian)* **Name**: ____
Address: ____
Telephone: _______________________________ **city** **state** **zip code**
Legal Status: ____

Chief Complaint: (*Briefly state why this person is being referred for a psychiatric evaluation)*

____

____

Family History of Mental Illness, Developmental Disabilities, or Neurological Illness:
(List all biological relatives who have a history of mental illness, mental retardation or neurological illness. Include periods of overt symptoms, suicide attempts, severe substance abuse, psychiatric hospitalization, and/or treatment as evidence.)
_______ **no information available** ____ **no family history of neuropsychiatric illness**

(List diagnoses or associated behaviors for family members with mental illness, mental retardation and/or neurological illness.)

Name **Relationship to Client**

____ ________________________

____ ________________________

Current Drug Therapy: (List all current medications)

Drug Name	Dosage	Times/Day	Result & Date of Most Recent Blood Level	Reason for Med

Past Reactions To Psychotropic Medications:

Medication with known positive effects:	Medication with known negative effects:	Other medications:

Other Treatments: *(Medical, PT, OT, etc)*

Drug Sensitivities: *(List unusual or negative reactions to any type of drug therapy.)*

History of Psychiatric Hospitalizations: *(List all psychiatric hospitalization.)*

Hospital	Dates of Stay	Diagnosis/Treatment

Current Diagnoses:	AXIS I:
	AXIS II:
	AXIS III:

Pregnancy and Delivery

1. Pregnancy: (____ no information available) Duration (in months) ___ complication: no ______ yes____ if yes, describe: ______________________________
2. Delivery: (_____no information available) Birth weight (if known): _______lbs ____oz Apgar score (if known): _______
   Delivery: spontaneous ______ induced _____ cesarean ______ Complications: no ____ yes _____ if yes, describe: ______________________________

Early Development

1. Milestones: (_____no information available)

toilet trained	spoke	sat up	walked	talked	urine	feces	1st words
______ mos.	_____ mos.	____ mos.	____ mos.	____ mos.	____ mos.	____ mos.	____ mos.

2. Mental retardation diagnosis: (____no information available)
   Age when diagnosis first made: ________________ Cause of mental retardation (if known): ____________________________
   ____
   Childhood Illnesses: ______________________________
   ____

Developmental Disabilities Information

1. Level of disabilities: (____no information available) ______ borderline intellectual function _____ mild ____ moderate ____severe ____profound ____unspecified
2. IQ testing: (____no information available)

Test Name	Date	Examiner	Full Scale	Perform	Verbal

3. Adaptive behavior testing: (____no information available)

Test Name	Date	Examiner	Results

Residential/Institutional Placements: *(Complete for clients who are currently living in or have lived in a state developmental center, state psychiatric hospital, or other residential facility for persons with developmental disabilities.)*

Admission to Facility	Date	Reason for Admission	Discharge Date

Ability Of Client To Participate In Interview/Others With Patient For Information:

Method Of Communication: Speech ________Signs (ASL)_____ Short Sentences____
Gestures ______Single Words____ Complete Sentences

Current Living Arrangements And Any Difficulties Noted: ______________________________
____

Current Occupational/Day Program And Any Difficulties Noted: ______________________________
____

Medical History

1. Does client have neurological problems?
   A seizure disorder? No____ yes ____ if yes, describe results or enclose report

Seizure Type	Date of Last Seizure	Age of Onset

   An abnormal EEG? No ____ yes ____ if yes, describe results or enclose report
   ____

   Has client had a CAT/MRI/PET scan? No ____ yes ___ if yes, describe results or enclose report
   ____

2. Does client have any other type of neurological problem? (i.e. History of head injury, Tardive Dyskinesia, Tics, Cerebral Palsy)
   No ____ yes ___ if yes, describe results or enclose report ______________________________

3. Does client have a specific HEENT problem? No ____ yes ___ if yes, describe results or enclose report
   ____

4. Does client have heart problems? (include abnormal EKG's) No ____ yes ___ if yes, describe results or enclose report
   ____

5. Does client have respiratory problems? No ____ yes ___ if yes, describe results or enclose report
   ____

6. Does client have gastrointestinal problems? No ____ yes ___ if yes, describe results or enclose report
   ____

7. Does client have gynecological or urinary problems? No ____ yes ___ if yes, describe results or enclose report
   ____

8. Does client have skin problems? No ____ yes ___ if yes, describe results or enclose report
   ____

9. Does client have Musculoskeletal problems? No ____ yes ___ if yes, describe results or enclose report
   ____

10. Does client have allergies? No ____ yes ___ if yes, describe results or enclose report
   ____

1. Does client have endrocrinological problems? (Diabetes, Hypothyroidism, etc)
   No ____ yes ___ if yes, describe results or enclose report______________________________

12. Does client have impaired vision? No ____ yes ___ if yes, describe results or enclose report
   ____

13. Does client have hearing or ear problems (ear infections, hearing loss)?
   No ____ yes ___ if yes, describe results or enclose report______________________________

14. Does client have a known genetic/MR syndrome? (Down's, PKU, etc)
   No ____ yes ___ if yes, describe results or enclose report ______________________________

15. Does client have feeding problems? (GERD, G-tube, dental status, etc)
   No ____ yes ___ if yes, describe results or enclose report ______________________________

16. Past Surgeries: No ____ yes ___ if yes, describe results or enclose report ____________________
   ____
   ____