

Paul A. Cannistraro, MD
Diagnostic Evaluation Form

Date: _____

Name: _____ **Date of Birth:** _____

SSN: _____

Address: _____

Home phone: _____

Work phone: _____

Cell phone: _____

What is the chief problem for which you are seeking treatment?

At what age did it start? _____

What are the main symptoms?

Does anyone in your family have any psychiatric or neurological illness? _____

Father: _____

Mother: _____

Siblings: _____

Relatives: _____

Were there any medical problems with your birth? _____

Were you developmentally delayed? _____

Did you have any behavioral problems as a child? _____

What kind of a student were you? _____

Did you have trouble with any particular subjects? _____

What is your highest level of education? _____

Did you ever have to take academic leave due to illness? _____

If so, what was the illness? Please also provide dates of academic leave.

Are you employed currently? _____

What is your position? _____

How long have you been there? _____

What is the longest held position you've had? _____

How long did you work there? _____

Have you ever had to stop work due to illness? _____

If so, what was the illness? Please also provide dates of work stoppage.

If unemployed now, when did you last work? _____

What was your last position? _____

What is your marital status? _____

If married- how long? _____

If separated or divorced- how long were you married? When did you separate?

Do you have any children? (please provide names and ages)

How would you describe your religious life?

Do you smoke? _____ How many per day? _____

How many years have you been smoking? _____

Do you drink alcohol? _____

At what age did you have your first drink? _____

How often do you currently drink? (specify average times per week or per month)

How much do you typically drink? (specify average number of drinks)

Describe any treatments you have received for drinking (with dates)

Do you or have you ever used street drugs? _____

List drugs, dates of first use, approximate frequency, and dates of last use

Describe any treatments you have received for drug use (with dates)

Who your psychiatrist? (if none, please list the last one you've seen)

Name: _____

Address: _____

Telephone: _____

Last seen: _____

Who is your therapist? (if none, please list the last one you've seen)

Name: _____

Address: _____

Telephone: _____

Last seen: _____

What medications do you take? (Please list doses and number of times per day)

Please list medications to which you have allergic reactions (describe reaction)

Please describe any psychiatric problems you have had in the past:

Problem 1 _____
Symptoms _____

Date of onset _____
Duration _____

Problem 2 _____
Symptoms _____

Date of onset _____
Duration _____

Problem 3 _____
Symptoms _____

Date of onset _____
Duration _____

Have you ever been hospitalized for a psychiatric problem? _____

If so, please list problem(s), hospital name, and approximate date and duration of hospitalization:

Please provide information about any psychiatric medications you have ever taken (use empty rows at the bottom of table for medications not listed):

Drug	Dates Taken	Max Dose	Therapeutic Effects	Side Effects
Paxil				
Prozac				
Zoloft				
Celexa				
Lexapro				
Luvox				
Effexor				
Wellbutrin				
Remeron				
Lithium				
Depakote				
Lamictal				
Klonopin				
Ativan				
Xanax				
Risperdal				
Seroquel				
Zyprexa				
Geodon				
Abilify				