Institute for Stress Control
501 West Ogden Avenue, Suite 6
Hinsdale, IL 60521

630/920-0900

Date: _____

QUESTIONNAIRE

Patient's Name: _____ **Date of Birth:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Telephone No.: _____ **Work Telephone No.:** _____

Cellular Telephone No: _____ **Male** _____ **Female** _____

Should it be necessary to reach you, what number should be called? _____

May we leave a discreet message? _____ **yes** _____ **no**

If the patient is not responsible for the bill, list the person(s) assuming that responsibility:

Name(s): _____

Date(s) of Birth: _____ **Soc. Security Number(s):** _____-

Complete Address(es): _____

_____

Telephone Numbers: Home No. : _____ **Work No.:** _____

Other No.: _____

Who referred you? _____

May we thank that practice/person for this referral? _____

MEDICAL INFORMATION

Patient's Family Physician: _____

Address: _____

_____

Telephone No.: _____

Please list any medical problems:

_____

_____

_____

Allergies? _____

_____

List all current medications including over the counter and prescription drugs. Please include the d*osage* and the *prescribing physician*.

_____

_____

Do you smoke cigarettes? _____ yes _____ no

If yes, specify number of cigarettes per day: _____

Age of first cigarette use: _____

Do you use alcohol? _____ yes _____ no

If yes, specifically list *number* of times you drink per week. _____

Specifically list how many drinks do you have when you do drink._____

What type of alcohol do you typically drink? _____

Age of first alcohol use: _____

Do you engage in any type of gambling activity? _____ yes _____ no

If yes, specifically list type and frequency of gambling. _____

Do you have access to a firearm or any other type of weapon? _____ yes _____ no

If yes, specify type and number: _____

MEDICAL HISTORY

Please note whether any *biological* relative has been diagnosed with any of the following conditions. Next to any condition that is marked "yes," list the relative's relationship to you. If there is any additional condition in your biological history that you think important, please list that condition.

Condition	No	Yes	Relationship
Alzheimer's Disease/Dementia			
Anxiety Disorder (including panic attacks)			
Attention Deficit/Hyperactivity Disorder			
Autism Spectrum Disorder			
Bipolar Disorder			
Depression			
Developmental Disability			
Learning disability			

Neurological disorder			
Obsessive Compulsive Disorder			
Process addiction (e.g., gambling)			
Seizure Disorder			
Substance abuse or addiction			
Suicide			
Tics (motor or vocal)			
Tourette's Disorder			

LIFE STYLE INFORMATION

Please list persons with whom you live and the nature of the relationship, e.g., mother, partner, spouse, etc.:_____

_____

_____

List types and frequency of your physical exercise/activity:

_____

_____

List regularly used stress reducing activities, e.g., walking, yoga, meditation, etc.:

_____

_____

On average how much sleep do you get each night? _____

Do you generally feeling well rested? _____ **yes** _____ **no**

How many times per week do you eat in a restaurant or have "fast food"? _____

How many hours per week do you watch television? _____

How many hours per week do you spend working at a computer? _____

Specify how many of those hours are employment related: _____

Do you generally find your employment satisfying?

_____ **yes** _____ **no**

If you have children, do you generally find parenting your children satisfying?
_____ yes _____ no

Feel free to add information. _____

_____

_____

List social activities, clubs, teams, etc. to which you belong: _____

_____

_____

Describe hobbies and/or pursuits that you enjoy: _____

_____

_____

Do you regularly participate in any activity – e.g., church services, AA meetings - that you would view as being spiritually oriented? ____ yes _____ no

Do you have close family ties? ____ yes ____ no

Feel free to add information. _____

_____

_____

Do you have a strong social support system, i.e., close friends, etc.? ____ yes ____ no

Feel free to add information. _____

_____

Please add any information that you think important.

_____

_____

Statement of Understanding

I understand that I am responsible for all fees related to my treatment. While an insurance plan may pay a portion of those charges, responsibility for payment rests with me since I received the services.

_____ _____
Signature of Patient (or Financially Responsible Person) **Date**