Behavioral Health Questionnaire
Claimant Name:  

Date of Birth:  

List Dates of Treatment (including first and most recent):  

Next Scheduled Office Visit:  

**DSM IV-TR DIAGNOSIS CODE AND DESCRIPTION**

Axis I:  

Axis II:  

Axis III:  

Axis IV:  

Axis V:  

Current GAF:  

Highest in past year:  

Baseline:  

(patient's usual ability to function)

Please provide Clinical Signs and Symptoms impacting functionality, intensity and duration which meet the DSM IV-TR Criteria for your above diagnosis (i.e. - cognitive impairment, functional impairment and suicidal/homicidal history and risk):

**MENTAL STATUS EXAM**

Date of Exam:  

Alertness:  

Orientation:  

Behavior/Psychomotor Speed:  

Speech:  

Mood:  

Affect:  

Thought Process:  

Thought Content:  

Judgment  

(please provide actual examples if judgment is poor):

Insight:  

Cognitive Impairment  

(please provide how assessed):
If your patient can not return to work full time, can your patient return to work on a part time or gradual basis?

A. Is your patient able to return to work full time? □ Yes □ No
B. If your patient cannot return to work full time, can your patient return to work on a part time or gradual basis? □ Yes □ No

If not, please describe any restrictions and limitations you are placing on your patient and provide the clinical observations and test results to support these findings.

PAST PSYCHIATRIC HISTORY

Has there been past treatment for this psychiatric diagnosis or any other psychiatric diagnosis? □ Yes □ No If yes, describe further:

Diagnosis: ____________________________
Treatment Received: ____________________________
Hospitalized: ____________________________

YOUR PATIENT’S SOCIAL INTERACTIONS/DEMEANOR

Please state current frequency and types of interactions with friends and family:

PERFORMANCE OF ACTIVITIES OF DAILY LIVING

Please describe your patient’s current activities of daily living (e.g. personal care, bathing, grooming, cooking, driving, managing check book, transportation):

What specific activities or tasks is your patient unable to perform to impact their ability to work?

TREATMENT/TREATMENT PLAN

Please list current medications, dosages and blood levels, if applicable.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
<th>Start Date</th>
<th>Last Change</th>
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Please indicate your treatment goals and target date for achievement of the treatment goals.
**Making Judgments and Decisions:**
Able to make generalizations, judgments, or decisions based on subjective or objective criteria such as with the five senses or with factual data.

**ABILITY TO PERFORM**
Please indicate your patient’s ability to perform the following Temperaments:

<table>
<thead>
<tr>
<th>Temperaments</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
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<tbody>
<tr>
<td>Directing, Controlling, Planning</td>
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<td>Performing Repetitive Work</td>
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<td>Influencing People</td>
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<td>Performing a Variety of Duties</td>
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<td>Expressing Personal Feelings</td>
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<td>Working Alone or in Isolation</td>
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<td>Performing Under Stress</td>
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<td>Attaining Precise Limits/Tolerances</td>
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<td>Following Specific Instructions</td>
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<td>Dealing with People</td>
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<td>Making Judgments and Decisions</td>
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Please summarize your patient’s functional psychological and cognitive strengths, abilities and limitations as it relates to concentration, memory, and/or attention. If there are no limitations in concentration, memory, and/or attention, how does this impact your patient’s ability to work? Please document the clinical observations and test results to support these findings.

**ALTERNATIVE WORK SETTING**
Can your patient currently perform his or her job duties in an alternative work setting? Yes No

Please Explain:

**PROVIDER INFORMATION**
Provider Name *(please print)*: 

Telephone #:

Address:

Fax #: 

Credentials (MD, DO, PhD, Other): 

Specialty:

Provider Signature: 

Date: