Date: ______/________/________

NAME: ______________________________ Birthdate: _____/_____/_____
Last First M. I.

Age:__________ Sex: ☐ F ☐ M

How did you hear about this clinic?

Describe briefly your present symptoms:

Please list the names of other practitioners you have seen for this problem:

Psychiatric Hospitalizations (include where, when, & for what reason):

Have you ever had ECT? Have you had psychotherapy?

CURRENT MEDICATIONS

Drug allergies: ☐ No ☐ Yes To what?

Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:

Name of drug	Dose (include strength & number of pills per day)	How long have you been taking this?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

PAST MEDICAL HISTORY

Do you now or have you ever had:

- ❑ Diabetes
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Hypothyroidism
- ❑ Goiter
- ❑ Cancer (type) ________________
- ❑ Leukemia
- ❑ Psoriasis
- ❑ Angina
- ❑ Heart problems
- ❑ Heart murmur
- ❑ Pneumonia
- ❑ Pulmonary embolism
- ❑ Asthma
- ❑ Emphysema
- ❑ Stroke
- ❑ Epilepsy (seizures)
- ❑ Cataracts
- ❑ Kidney disease
- ❑ Kidney stones
- ❑ Crohn's disease
- ❑ Colitis
- ❑ Anemia
- ❑ Jaundice
- ❑ Hepatitis
- ❑ Stomach or peptic ulcer
- ❑ Rheumatic fever
- ❑ Tuberculosis
- ❑ HIV/AIDS

Other medical conditions (please list):

PERSONAL HISTORY

Were there problems with your birth? (specify)

Where were your born & raised?

What is your highest education? ❑High school ❑Some college ❑College graduate ❑Advanced degree

Marital status: ❑ Never married ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Partnered/significant other

What is your current or past occupation?

Are you currently working? : ❑ Yes ❑ No Hours/week ______ If not, are you ❑ retired ❑ disabled ❑ sick leave?

Do you receive disability or SSI? ❑ Yes ❑ No If yes, for what disability & how long?____________________

Have you ever had legal problems? (specify)

Religion:

FAMILY HISTORY

	IF LIVING		IF DECEASED	
	Age (s)	Health & Psychiatric	Age(s) at death	Cause
Father				
Mother				
Siblings				
Children				

EXTENDED FAMILY PSYCHIATRIC PROBLEMS PAST & PRESENT:

Maternal Relatives:

Paternal Relatives:

Have you ever seen a psychiatrist? Yes ________ No ________

Have you ever had individual therapy? Yes ________ No ________

Have you had in-patient hospitalization? Yes ________ No ________

If yes, with whom and for how long were you treated?

____

____

____

What are your current mental health medications?

Medication	Dosage	Frequency	For What

Have you taken previous medications for your mental health (dosage, duration and response)?

Medication	Dosage	Duration	Response

Any other prescribed medication?

Medication	Dosage	Frequency	For What

Any over-the-counter medications, vitamins or other supplements?

Medication	Dosage	Frequency	For What

Have you had allergic reactions or other problems with medications? Yes ________ No ________

If yes, please list the medications and the reaction or problem:

____

____

____

What medical problems do you have? Do you have a history of head injury?

____

____

____

List type and dates of any medical hospitalizations and/or surgeries you have had:

____

____

____

Have you ever been hospitalized for psychiatric reasons? Yes ________ No ________

If yes, please state when and cause:

____

____

____

Have you ever attempted suicide? Yes ________ No ________

If yes, how? ____

When: ____

Treatment received: ____

Are you having thoughts of harming yourself or others such as your spouse or children? Yes ________ No ________

How much caffeine do you have a day? ________________________________

Do you smoke? Yes ________ No ________ How many cigarettes per day? ________________

Have you ever had problems with drinking alcohol? Yes ________ No ________

Do you desire to cut down use? Yes ________ No ________

Have others been annoyed at your use? Yes ________ No ________

Do you have guilt about use? Yes ________ No ________

Do you often have an "eye opener" to avoid withdrawal symptoms? Yes ________ No ________

How much alcohol are you consuming in a week, including beer and wine? ____________________________

Have you ever been in treatment for alcohol/drug use? Yes ________ No ________

If yes, please state where and dates of treatment:

____

____

____

SUBSTANCE USE

DRUG CATEGORY (circle each substance used)	Age when you first used this:	How much & how often did you use this?	How many years did you use this?	When did you last use this?	Do you currently use this?
ALCOHOL					Yes ☐ No ☐
CANNABIS: Marijuana, hashish, hash oil					Yes ☐ No ☐
STIMULANTS: Cocaine, crack					Yes ☐ No ☐
STIMULANTS: Methamphetamine—speed, ice, crank					Yes ☐ No ☐
AMPHETAMINES/OTHER STIMULANTS: Ritalin, Benzedrine, Dexedrine					Yes ☐ No ☐
BENZODIAZEPINES/TRANQUILIZERS: Valium, Librium, Halcion, Xanax, Diazepam, "Roofies"					Yes ☐ No ☐
SEDATIVES/HYPNOTICS/BARBITURATES: Amytal, Seconal, Dalmane, Quaalude, Phenobarbital					Yes ☐ No ☐
HEROIN					Yes ☐ No ☐
STREET OR ILLICIT METHADONE					Yes ☐ No ☐
OTHER OPIOIDS: Tylenol #2 & #3, 282'S, 292'S, Percodan, Percocet, Opium, Morphine, Demerol, Dilaudid					Yes ☐ No ☐
HALLUCINOGENS: LSD, PCP, STP, MDA, DAT, mescaline, peyote, mushrooms, ecstasy (MDMA), nitrous oxide					Yes ☐ No ☐
INHALANTS: Glue, gasoline, aerosols, paint thinner, poppers, rush, locker room					Yes ☐ No ☐
OTHER: specify)__________					Yes ☐ No ☐

SYSTEMS REVIEW

In the past month, have you had any of the following problems?

GENERAL
- ❑ Recent weight gain; how much____
- ❑ Recent weight loss: how much____
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever
- ❑ Night sweats

MUSCLE/JOINTS/BONES
- ❑ Numbness
- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Joint swelling

Where?

EARS
- ❑ Ringing in ears
- ❑ Loss of hearing

EYES
- ❑ Pain
- ❑ Redness
- ❑ Loss of vision
- ❑ Double or blurred vision
- ❑ Dryness

THROAT
- ❑ Frequent sore throats
- ❑ Hoarseness
- ❑ Difficulty in swallowing
- ❑ Pain in jaw

HEART AND LUNGS
- ❑ Chest pain
- ❑ Palpitations
- ❑ Shortness of breath
- ❑ Fainting
- ❑ Swollen legs or feet
- ❑ Cough

NERVOUS SYSTEM
- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting or loss of consciousness
- ❑ Numbness or tingling
- ❑ Memory loss

STOMACH AND INTESTINES
- ❑ Nausea
- ❑ Heartburn
- ❑ Stomach pain
- ❑ Vomiting
- ❑ Yellow jaundice
- ❑ Increasing constipation
- ❑ Persistent diarrhea
- ❑ Blood in stools
- ❑ Black stools

SKIN
- ❑ Redness
- ❑ Rash
- ❑ Nodules/bumps
- ❑ Hair loss
- ❑ Color changes of hands or feet

BLOOD
- ❑ Anemia
- ❑ Clots

KIDNEY/URINE/BLADDER
- ❑ Frequent or painful urination
- ❑ Blood in urine

Women Only:
- ❑ Abnormal Pap smear
- ❑ Irregular periods
- ❑ Bleeding between periods
- ❑ PMS

PSYCHIATRIC
- ❑ Depression
- ❑ Excessive worries
- ❑ Difficulty falling asleep
- ❑ Difficulty staying asleep
- ❑ Difficulties with sexual arousal
- ❑ Poor appetite
- ❑ Food cravings
- ❑ Frequent crying
- ❑ Sensitivity
- ❑ Thoughts of suicide / attempts
- ❑ Stress
- ❑ Irritability
- ❑ Poor concentration
- ❑ Racing thoughts
- ❑ Hallucinations
- ❑ Rapid speech
- ❑ Guilty thoughts
- ❑ Paranoia
- ❑ Mood swings
- ❑ Anxiety
- ❑ Risky behavior

OTHER PROBLEMS:

WOMENS REPRODUCTIVE HISTORY:

Age of first period:

Pregnancies:

Miscarriages:

Abortions:

Have you reached menopause? Y / N At what age?

Do you have regular periods? Y / N

PATIENT PROBLEM SURVEY

Below is a list of problems people sometimes have. Please read each one carefully and check which best describes how much that problem has bothered you ***during the past seven days***.

How much are you distressed by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
Crying easily					
Thoughts of ending your life					
Planning to end your life					
Blaming yourself for things					
Feeling depressed					
Loss of sexual interest or pleasure					
Change in appetite					
Feeling no interest in things					
Feeling hopeless about the future					
Feelings of worthlessness					
Feelings of guilt					
Change in sleep pattern					
History of hyperactivity					
Avoiding family, friends and other social activities					
Fears about gaining weight or becoming fat					
Restricting food to lose weight					
Vomiting or using laxatives to lose weight					
Impulsive behaviors					
Period of intense and/or excessive spending					
Periods of racing thoughts					
Repeated unpleasant thoughts that don't leave					
Trouble remembering things					
Difficulty concentrating					
Difficulty making decisions					
Having to repeat the same actions such as checking, counting or washing					
Trouble in your job					
Nervousness or shakiness inside					
Uncontrollable worrying					
Trembling					

How much are you distressed by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
Heart pounding or racing					
Episodes of terror or panic					
Feeling that something bad is going to happen					
Feeling fearful of specific situations					
Feeling afraid to leave your house					
Uncomfortable around new people/situations					
Feeling easily annoyed or irritated					
Temper outbursts that you could not control					
Having urges to beat, injure or harm someone					
Feeling others are to blame for your troubles					
Feeling that you are watched or talked about by others					
The idea that someone else controls your thoughts					
Hearing voices that other people do not hear					
Other people being aware of your private thoughts					
Having thoughts that are not your own					
The idea that you should be punished for your sins					
The idea that something serious is wrong with your body					
Headaches					
Nausea or upset stomach					
Constipation or diarrhea					