

NOTE: Please print or write legibly and make answers complete but brief. If you do not understand a question or a word, please contact us promptly for help. Time you devote to providing accurate information here will be well spent, because the doctor will rely on that information in completing his evaluation. This information will become part of your confidential record.

The information on the following pages is accurate to the best of my knowledge and ability:

Signature (patient/parent/guardian) _____

Name of person completing this form: _____

Relationship to patient: _____

NOTE: Questions are worded as if the patient is answering.

Today's Date: _____

Identification: Patient Name: _____ Date of Birth: _____

CHIEF COMPLAINT: Why did you want to see us? Why did you seek an appt now instead of earlier or later?

HISTORY OF PRESENT ILLNESS: *Use additional pages or the back of this page to answer, if necessary.*

When in your life did you first experience a problem like this? _____

What has been the frequency and duration of these problems? _____

What have you done to gain relief from these problems? _____

What else should I know about this condition? _____

Current Psychiatric Medications:

Medication	Dose	Frequency	Started When	Who Prescribes
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

All Other Current Medications: (please include over-the-counter medications, vitamins, supplements, herbs, etc)

Medication	Dose	Frequency	Started When	Who Prescribes
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Past Psychiatric Medications:

Medication Allergies:

Medication	Reaction	Medication	Reaction
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

SOCIAL HISTORY:

Marital History: Married Divorced Separated Widowed Never married Other: _____
 How long have you been married? _____ How many times have you been married? _____ *describe*
 How many children do you have? _____ How many of them live with you? _____
 Does anyone other than immediate family members live with you? Yes No (who?) _____

Legal History:

Do you currently have any legal problems? (describe) _____
 Previous Arrests/Convictions: Charge _____ Year _____

History of Military Service: Yes No Dates of Service: _____
 Served in combat? Yes No Where? _____ Type of Discharge: _____

Employment History: Are you currently employed? Yes No
 Current Job _____ Career Occupation _____
 How many jobs have you had in the past five years? _____ Have you ever been fired from a job? _____

Educational History: Highest grade completed? _____ Do you plan to return to school/training? _____
 Degree(s), certificate(s), license(s)? _____

Sexual History: What is your sexual orientation? _____ (straight, bi-, gay, asexual, etc)
 Are you sexually active? _____ How many sexual partners in the last 5 years? _____
 Any issues or problems _____

Traumatic Events: What traumatic events have you experienced or witnessed? (When? / describe)

Special Senses: Do you have any special senses or gifts? (describe) _____

PATIENT'S MEDICAL HISTORY:

Do you have a family physician? Yes No Who/Where _____
 When were you last treated or examined by a physician? _____
 Chronic or serious illnesses: _____

Injuries, surgeries, hospitalizations (non-psychiatric):	Year	Where
_____	_____	_____
_____	_____	_____

Do you currently have or have you had in the past, any of the following conditions? Heart attack Stroke
 High blood pressure Thyroid disease Eating disorder Seizures Head injury Loss of consciousness
 Autoimmune issues HIV/AIDS Diabetes Cancer Kidney disease Neurological condition
 Other conditions _____ Number of Pregnancies _____

Family Medical History (other than yourself):

Problem	Relative
<input type="checkbox"/> Diabetes	_____
<input type="checkbox"/> Kidney disease	_____
<input type="checkbox"/> Cancer	_____
<input type="checkbox"/> Stroke	_____
<input type="checkbox"/> High blood pressure	_____
<input type="checkbox"/> Epilepsy/Seizures	_____
<input type="checkbox"/> Thyroid disease	_____
<input type="checkbox"/> Other conditions that run in your family	_____

PATIENT'S PSYCHIATRIC HISTORY:

Last psychiatric hospitalization: Date: _____ Place: _____ Duration: _____

Before that, how many times in your life had you been admitted to a psychiatric hospital/ward? _____

Facility Name	When	Type of treatment	Length of stay
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Last Outpatient Psychiatrist: _____ When: _____ Where: _____

Last Outpatient psychotherapist or counselor: _____ When: _____ Where: _____

Do you have problems with anxiety? Yes No. Briefly describe: _____

Do you have problems with depression? Yes No Briefly describe: _____

History of suicidal impulse? Yes No. Circumstances? _____

History of suicide attempts? Yes No. How many? _____ When: _____

History of self-injurious behavior ? (deliberately injuring or inflicting pain upon yourself) Yes No

Have you ever experienced a manic episode? Yes No. Briefly describe: _____

Have you ever been told you have schizophrenia? Yes No

Have you ever been physically abused? Yes No

Have you ever been sexually abused? Yes No

Have you ever been emotionally or mentally abused? Yes No

Was the abuse reported? Yes No. To whom? _____

Family Psychiatric History (other than yourself):

Problem	What relative(s)?	Problem	What relative(s)?
<input type="checkbox"/> Anxiety	_____	<input type="checkbox"/> ADHD	_____
<input type="checkbox"/> Depression	_____	<input type="checkbox"/> Bipolar Disorder	_____
<input type="checkbox"/> Obsessive/Compulsive Disorder	_____	<input type="checkbox"/> Schizophrenia	_____
<input type="checkbox"/> Attempted Suicide	_____	<input type="checkbox"/> Suicide	_____
<input type="checkbox"/> Other (please describe)	_____		

SUBSTANCE USE HISTORY:

Alcohol

Do you drink alcohol now? Yes No
What do you drink? _____ How often? _____ How much? _____
At what age did you first begin drinking alcohol? _____ At what age did you drink the most? _____
Do you drink in the morning? Yes No
Have you ever blacked out due to intoxication? Yes No
Have you ever been arrested for a DUI? Yes No
Have you ever been arrested for Public Intoxication? Yes No
What withdrawal symptoms have you experienced? tremors sweats fast heart rate irritability
 confusion delirium tremens hallucinations - visual auditory tactile
Do you believe alcohol has affected your work relationship with others health (check all that apply)
Do you think you have a problem with alcohol? Yes No

Tobacco Products

Do you smoke? _____ How many packs per day? _____ Do you chew tobacco? _____ How much? _____
How many years have you used tobacco? _____

Other Drugs

Please list the drugs (speed, crank, amphetamines, uppers, downers, coke, cocaine, crack, heroin, LSD, psychedelic mushrooms, marijuana, pot, glue, gas, other huffing agents, hash, opium, any consciousness altering or recreational drug) that you use or have used.

Name of drug	Age began	When last used	How often & how much used
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Family History

Does any member of your family drink heavily? Yes No
Does any member of your family abuse drugs? Yes No
Which drugs? _____
Has any family member been treated for alcoholism or drug addiction? Yes No
(list relationships) _____
Has alcohol or drug use lead to legal problems for any family member Yes No

Substance Abuse Treatment History:

Have you ever been treated for use of alcohol or drugs? Yes No
How many times have you been treated? _____

Facility Name	When	Type of treatment	Length of sobriety
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

What is your longest period of sobriety since you began drug use or drinking? _____

Do you attend a group like AA or NA? Yes No Do you have a sponsor? Yes No

Symptom Check List

Please use the following codes to complete the check list:

1 = False, Never true
2 = Sometimes true

3 = Mostly true
4 = Very or always true

Symptom					Comments
Difficulty getting to sleep	1	2	3	4	_____
Frequent nightmares	1	2	3	4	_____
Difficulty staying asleep	1	2	3	4	_____
Feeling tired in the morning	1	2	3	4	_____
Go days without sleeping	1	2	3	4	_____
No interest in doing things	1	2	3	4	_____
Give up easily with tasks	1	2	3	4	_____
Feeling guilty	1	2	3	4	_____
Overwhelming worry	1	2	3	4	_____
Aggressive when stressed	1	2	3	4	_____
Feelings of worthlessness	1	2	3	4	_____
Feeling lonely	1	2	3	4	_____
Too much energy	1	2	3	4	_____
Concentration is poor	1	2	3	4	_____
Attention span is poor	1	2	3	4	_____
Distracted easily	1	2	3	4	_____
Appetite is poor	1	2	3	4	_____
Force self to vomit	1	2	3	4	_____
Go days without eating	1	2	3	4	_____
Binge on food	1	2	3	4	_____
Feel restless or nervous	1	2	3	4	_____
Feel tense or keyed up	1	2	3	4	_____
Feel weak in parts of body	1	2	3	4	_____
Thoughts of suicide	1	2	3	4	_____
Thoughts of killing people	1	2	3	4	_____
Difficulty accepting change	1	2	3	4	_____
Check locks frequently	1	2	3	4	_____
Always counting numbers	1	2	3	4	_____
Washing hands frequently	1	2	3	4	_____
Very dependent on others	1	2	3	4	_____
Many daily rituals	1	2	3	4	_____
Express emotions intensely	1	2	3	4	_____
Withdraw under stress	1	2	3	4	_____
Scared for no reason	1	2	3	4	_____
Spells of terror or panic	1	2	3	4	_____
Afraid to go out of home	1	2	3	4	_____
Hear voices in my head	1	2	3	4	_____
Messages from radio or TV	1	2	3	4	_____
People are out to hurt me	1	2	3	4	_____
Other: _____	1	2	3	4	_____

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The information on this page is accurate to the best of my knowledge and ability:

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Name of person completing this form: _____ Relationship to patient: _____

NOTE: Questions are worded as if the patient is answering.

Developmental History: How was your mother's health during pregnancy? _____

If any of the following were present, please check: severe nausea and vomiting weight loss anemia
 marked weight gain (over 30 pounds) high blood pressure fever or infections other (please describe – smoking, alcohol, drugs, and/or medical illness during pregnancy) _____

Was there bleeding during pregnancy? Yes No Unknown

If yes: 1st to 3rd month 3rd to 6th month 6th to 9th month

Were you a full term infant? _____

What was your birth weight? _____ Were you in an incubator? No Yes. How long _____

What physical deformities did you have at birth? _____

Did you have any problems as an infant? (describe) _____

How would your mother describe you during your first six months of life: mildly active serious

crying quiet cuddly-affectionate kicking-restless smiling-cooing whining

alert other (please describe) _____

Please give an approximate age for mastery of: _____ walking alone _____ using single words with meaning

Have you ever been told you had any delays in speech or language? Yes No

At what age did you achieve complete bladder and bowel control? _____

Did you have problems in school? Yes No Did you have problems making friends? Yes No

Information on Father

Name _____

Natural Step Foster Adoptive

Age _____ Education _____

Marital status of biological parents (check appropriate spaces):

separated parents divorced mother remarried

other (describe) _____

Information on Mother

Name _____

Natural Step Foster Adoptive

Age _____ Education _____

living together one parent deceased

father remarried not married

Describe any behavior problems that occurred at home: _____

Have you ever lived in a foster home, group home, or residential center? Yes No Age _____

Who had/has legal custody of you? _____

Did you ever have to repeat a grade? No Yes. What age & grade and why? _____

Have you had any learning problems – including difficulty with reading or mathematics? Yes No

Please describe: _____

Describe any behavior problems that occurred at school: _____

Were you ever suspended or expelled from school? Yes No Age: _____. If yes, for what reason?

Have you missed many days of school in the past year? Yes No How many? _____. Why? _____

Have you ever been seen by a juvenile court worker? Yes No Age: _____. Why? _____

Please list organized social, community, or recreational activities (e.g. 4-H, Scouts, sports)

Who disciplines you? mother father both other _____

How are you disciplined? spanking isolation mild slapping discussion deprivation

scolding withdrawal of affection loss of privileges. Are these methods effective? Yes No