Date: _______/_________/________

NAME: ____ Birthdate: _____/______/_____

Last First M. I.

Age:___________ Sex: ❑ F ❑ M

How did you hear about our clinic?

Describe your present symptoms:

Please list the names of other health care providers 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 List:

Please list any medications that you are taking. Please 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.		

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PAST MEDICAL HISTORY		
Do you now or have you ever had:		
❑ Diabetes	❑ Heart murmur	❑ Crohn's disease
❑ High blood pressure	❑ Pneumonia	❑ Colitis
❑ Depression, or other mood disorders	❑ Pulmonary embolism	❑ Anemia
❑ Hypothyroidism	❑ Asthma	❑ Jaundice
❑ Coronary Artery Disease	❑ Emphysema/COPD	❑ Hepatitis/Liver Disease
❑ Cancer (type) __________________	❑ Stroke	❑ GERD or peptic ulcer
❑ Peripheral Vascular Disease	❑ Epilepsy (seizures)	❑ Rheumatic fever
❑ Psoriasis	❑ Schizophrenia	❑ Tuberculosis
❑ Angina	❑ Kidney disease	❑ HIV/AIDS
❑ Sleep Apnea	❑ Kidney stones	
❑ High cholesterol		
Other medical conditions (please list):		

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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?___________________________

Do you use tobacco? Yes/No If so, which form:________________________________ How long:_____________

Religion:

FAMILY HISTORY
Mother: alive/deceased Medical problems:
Father: alive/deceased Medical problems:
Children: Males/ages: Females/ages:

EXTENDED FAMILY PSYCHIATRIC PROBLEMS PAST & PRESENT:
Maternal Relatives:

Paternal Relatives:

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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

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
- ❑ Anemia

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

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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

KIDNEY/URINE/BLADDER

❑ Frequent or painful urination

❑ Blood in urine

Women Only:

❑ Abnormal Pap smear

❑ Irregular periods

❑ Bleeding between periods

❑ PMS

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

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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 □

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