|  |
| --- |
| Please explain the reason for your visit and why now? |
| Allergies: |
| Current level of stress 1-10: Primary stressors? |
| Primary care physician: |
| Name, address, phone, fax: |
| Date of last check up with PCP: |
| Symptoms circle all that apply this year: |
| Anger Addiction |
| Anxiety Appetite increased |
| Aggressive behavior Appetite decreased |
| Attention/ concentration impairment Compulsive behavior |
| Depression mood Disorganization |
| Fatigue/ tiredness Fear & phobias |
| Feelings of guilt Feelings of hopelessness |
| Flashbacks of traumatic event Eating problems |
| Gambling excessively Hallucinations |
| Headaches Impaired relationships |
| Impaired productivity at work or school Pornography use |
| Impulsive behavior Inability to enjoy activities |
| Irritability Indecisiveness |
| Loneliness Memory impairment |
| Moodiness Nausea |
| Obsessive thinking Overuse of alcohol/drugs |
| Procrastination Pain-general |
| Perfectionism Paranoid thoughts |
| Panic Racing thoughts |
| Restlessness Stress |
| Seasonal mood Self-harm (cutting etc.) |
| Sexual difficulties Shopping excessively |
| Suicidal thoughts Tearfulness |
| Worry Weight gain/ loss |
| Any other symptoms:Physical symptoms: Circle all that you currently have or had this year. Please comment when necessary. |
| Asthma Allergies |
| Bleeding problems Bone loss |
| Bruising Constipation |
| Chest pains Digestive problems |
| Diarrhea Dizziness |
| Endocrine issues Eye sight/ vision changes |
| Fever Heart disease |
| Hearing problems High blood pressure |
| Infections Inflammation |
| Involuntary movements Irregular heart beat |
| Joint pain Lung or sinuses |
| Muscle pain Nightmares |
| Numbness Passing out |
| Reproductive issues/ PMS Seizures |
| Snoring Stomach pains |
| Tics Weakness |
| **Please comment on any of the items circled above:** |
| **Any other medical conditions you have had not listed above:** |
| **Serious injury and illnesses:** |
| **Have you had any of the following tests? When, where, what was the outcome?** |
| Sleep Study Psychological Testing |
| Brain MRI / CT Scan EEG |
| Thyroid Tests EKG |
|  |
| **Health habits: How much and how often? In the past, how many years, how often, what age did you stop and why?** |
| Alcohol |
| Caffeine |
| Drugs |
| Tobacco |
| Sexually active |
| Pornography |
| Exercise |
| Meditation practice |
| Acupuncture |
| Massage therapy |
| Other |
| **Substance abuse treatment history:** |
| **Please circle all that apply. How long and what dates.** |
| AA/12 step groups |
| Substance abuse inpatient treatment |
| Substance abuse outpatient treatment |
| Substance abuse residential treatment |
| Court ordered treatment |
| Rational recovery |
| Al-anon |
| **Education history & dates of completion** |
| High school Vocational degree |
| Associates degree Bachelor’s degree |
| Master’s degree Doctoral degree |
| Post-doctoral studies Professional certification |
| **What was your degree in?** |
| **Employment status** |
| Full- time Part- time Self-employed Student |
| Homemaker Retired Disabled Unemployed |
| **Employer name and position / title:**  **Describe the type of work that you do?** |
| **Legal history – Please circle and include relevant dates.** |
| None DUI Public intoxication |
| Assault Theft Other: |
| **Comments:** |
| **Religious/spiritual background**  *please circle* |
| Christian Catholic Jewish |
| Muslim Mormon Jehovah’s witness |
| Agnostic Atheist Buddhist Other: |
| **Sleep history** |
| Unable to sleep Hypersomnia/ too much sleep Sleep apnea  Difficulty falling asleep Difficulty staying asleep Minimal sleep but feel fine  Nightmares Sleep walking Comments: |
| Current prescription and non-prescription medications: Date started |
| 1. |
| 2. |
| 3. |
| 4. |
| 5. |
| 6. |
| Past medication history: Comments, side effects and start/ stop dates: |
| 1. |
| 2. |
| 3. |
| 4. |
| Family history: Family member |
| Depression |
| Anxiety |
| Bipolar disorder |
| Tic/ Tourette’s |
| Physical abuse |
| Sexual abuse |
| Domestic violence |
| Suicide |
| Psychosis |
| Alcoholism |
| Substance abuse |
| Attention problems |
| Obsessive/ compulsive |
| Trauma |
| Schizophrenia |
| Dementia |
| Children: Age Health status School/ grade |
| 1. |
| 2. |
| 3. |
| 4. |
| 5. |
| Family History: |
| Adopted (Please circle) Yes No If yes, at what age? |
| Family of origin: Age Health status (if deceased please provide date) Quality of relationship |
| Mother |
| Father |
| Step- mother |
| Step-father |
| Foster family |
| Brothers |
| Step-brothers |
| Half-brothers |
| Sisters |
| Step- sisters |
| Half-Sisters |
| Any other relevant family history: |
| Current relationship status: Single, Married, Divorced, Widowed, Living Together, Separated **Describe your current relationship:** (Please include current partner’s name and the length of your current relationship.)  **Please describe prior relationship history:** |
| Do you have support from extended family and friends? |
| Treatment history: |
| Hospitalizations: Name of hospital Reason for admission Dates |
| 1. |
| 2. |
| 3. |
| 4. |
| Prior psychotherapy: Name Address Phone number |
| 1. |
| 2. |
| 3. |
| Prior psychiatric care: Name Address Phone number |
| 1. |
| 2. |
| 3. |

I certify that the above information is correct to the best of my knowledge and that I have not purposefully misrepresented my health history. I will not hold my doctors or any members of their staff responsible for error or omissions that I may have made in completing this form.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature/ date

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Reviewed by/ date: