

Name _____ Date _____

Preferred name _____ Age _____ Date of Birth _____

Pronouns _____

Phone number _____ E-mail _____

Address _____

Pharmacy _____

Emergency contact _____ Relationship _____ Phone _____

Referred by _____

What are the issues for which you are seeking care?

Have you ever had any of the following conditions? (Check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> HIV positive or AIDS |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Immunological disease |
| <input type="checkbox"/> Cardiac structural problems | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Chronic pain/Fatigue | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lung disease |
| <input type="checkbox"/> Gastrointestinal problems | <input type="checkbox"/> Mouth, nose or throat problems |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Neurological problems |
| <input type="checkbox"/> Gynecological problems | <input type="checkbox"/> Seizure |
| <input type="checkbox"/> Hormone problems | <input type="checkbox"/> Sleep apnea |
| <input type="checkbox"/> Head injury | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> High or low blood pressure | <input type="checkbox"/> Urological problems |

Have you experienced any of the following symptoms in the past month? (Check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Thoughts about harming self | <input type="checkbox"/> Increased irritability |
| <input type="checkbox"/> Thoughts about harming other/others | <input type="checkbox"/> Excessive energy |
| <input type="checkbox"/> Recurrent thoughts of death | <input type="checkbox"/> Decreased need for sleep |
| <input type="checkbox"/> Suicide attempt | <input type="checkbox"/> Sexual indiscretion |
| <input type="checkbox"/> Depressed mood | <input type="checkbox"/> Excessive spending |
| <input type="checkbox"/> More depressed in the winter | <input type="checkbox"/> Increased risky behavior |
| <input type="checkbox"/> Loss of interest in activities | <input type="checkbox"/> Intrusive thoughts |
| <input type="checkbox"/> Excessive guilt | <input type="checkbox"/> Impulsivity |
| <input type="checkbox"/> Feelings of worthlessness | <input type="checkbox"/> Rituals |
| <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Fear of gaining weight |
| <input type="checkbox"/> Moving slower than usual | <input type="checkbox"/> Restricting calories |
| <input type="checkbox"/> Moving faster than usual | <input type="checkbox"/> Binging on food/compensatory behavior |
| <input type="checkbox"/> Decreased concentration | <input type="checkbox"/> Hallucinations (auditory, visual, tactile) |
| <input type="checkbox"/> Increased appetite/weight gain | <input type="checkbox"/> Delusions |
| <input type="checkbox"/> Decreased appetite/weight loss | <input type="checkbox"/> Paranoia |
| <input type="checkbox"/> Sleeping too much | <input type="checkbox"/> Self-harm behavior |
| <input type="checkbox"/> Difficulty falling asleep | <input type="checkbox"/> Chronic feelings of emptiness |
| <input type="checkbox"/> Difficulty staying asleep | <input type="checkbox"/> Fear of abandonment |
| <input type="checkbox"/> Nightmares | <input type="checkbox"/> Unstable relationships |
| <input type="checkbox"/> Flashbacks | <input type="checkbox"/> Difficulty controlling anger |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Frequent mood changes in course of a day |
| <input type="checkbox"/> Feeling nervous or on edge | <input type="checkbox"/> Fear of embarrassment |
| <input type="checkbox"/> Muscle tension | <input type="checkbox"/> Social situations avoided |
| <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Alcohol or substance abuse |

Allergies _____

Current medical problem(s) _____

Current medications and/or supplements (prescribed or non-prescribed):

Name	Dose	Frequency	Estimated start date

Primary care provider (PCP) : _____ Date of last physical: _____

Do you give consent to communicate with your PCP, if needed? Yes No

For women

Is there a chance that you might be pregnant? Yes No Maybe

Are you planning to become pregnant in the next 6 months? Yes No Maybe

Psychiatric History

Have you ever seen a psychiatrist? Yes No Name: _____

 If yes, do you give consent to communicate with your psychiatrist, if needed? Yes No

Have you ever seen a psychologist, therapist or other mental health professional? Yes No

 If yes, name/location of the services _____

Reasons services utilized & for how long? _____

Reasons for discontinuation _____

Have you ever had psychological evaluation? If yes, reason _____

Past suicide attempt(s)?

Date	Age	Mean(s) used	Treatment received?	Hospitalized?

Non-suicidal self-harm?

Date	Age	Method(s) used	Treatment received?	Hospitalized?

Do you have access to firearm? Yes No

Past psychiatric diagnoses (Check all that apply)

- Addiction
- Anxiety
- Attention deficit hyperactivity disorder (ADHD)
- Bipolar disorder
- Dementia
- Depression
- Eating disorder
- Impulse control disorder
- Obsessive-compulsive disorder (OCD)
- Panic disorder
- Personality disorder
- Post-traumatic stress disorder (PTSD)
- Psychosis
- Schizophrenia
- Other: _____

Previous psychiatric medications

Name of Medicine	Highest daily dose	Total duration	Effective? (Yes/No)	Reason for discontinuation

Past treatment/hospitalizations

Please include substance abuse treatment/rehab, Partial Hospitalization (PHP), Intensive Outpatient (IOP), ECT, TMS.

Location	Approximate Dates	Reason

Family history of mental illness

Please include any biological members of your family, maternal and/or paternal.

Mental health diagnosis/addiction/genetic diagnosis	Relationship
Suicide completed/attempted?	Relationship

Substance use

Do you currently smoke cigarettes/or vape e-cigs? Yes No If yes, how many per day? _____

Do you use other tobacco products? Yes No If yes, what type? _____

Do you drink alcohol? Yes No If yes, how many days per week? _____

Do you use marijuana or other recreational drugs? Yes No

If yes, please specify _____ How frequently? _____

Have you ever abused prescription medication? Yes No If yes, which one(s)? _____

Have you ever consumed recreational substances intravenously or shared needles? Yes No

Do you believe you struggle with substance use? Yes No

Does a family member/friend think you struggle with substance use? Yes No

Are you interested in receiving treatment/resources? Yes No

Social History

Where were you born? _____ Where did you grow up? _____

Who were you raised by? _____

Overall, how would you describe your childhood? _____

What was your highest level of education? _____

Degree(s) earned: _____

What is your current occupation? _____

Are you currently married or in a relationship? Yes No Partner's Name: _____

What is your living situation? _____

Do you feel safe in your current environment? _____

From whom do you receive emotional support? _____

Current legal problems? Yes No If yes, please specify _____

Are you involved with a religious or spiritual group? _____

What do you do for fun? _____

Is there anything else you would like us to know?

What do you hope to accomplish in treatment?

