Name: ____

Date of Birth:_________ Primary Care MD:___________________ MD phone: _____________________

Current therapist (if applicable) : __________________ Therapist's Phone_______________________

By whom were you referred (if applicable) : ____

For what are you seeking help?

____

____

Please rate the following in the past 2 weeks

Feeling	None	Mild / Moderate	Severe
Sadness/irritability			
Loss of interest			
Decreased energy			
Changes in appetite			
Changes in sleep			
Hopelessness			
Worthlessness			
Poor memory			
Poor concentration			
Suicidal thoughts			
Guilt			
Worsening physical pain			
Unintended changes in weight			

MEDICAL HISTORY:

Please list allergies: _____________________________________

Please list ALL Current Prescription medications (or bring complete list to appointment):

______________________________________ ______________________________________

______________________________________ ______________________________________

______________________________________ ______________________________________

______________________________________ ______________________________________

______________________________________ ______________________________________

______________________________________ ______________________________________

______________________________________ ______________________________________

______________________________________ ______________________________________

Please list over the counter supplements: ____

Please circle the medical conditions that apply, please describe:

Hypertension: ______________

High cholesterol: _____________

Atrial fibrillation: _______________

Thyroid abnormalities: ___________

COPD: _____________________

Diabetes: ______________________

Osteoporosis: _________________

Thyroid abnormality: ____________

Kidney Impairment: _____________

Cancer: _______________________

Liver disease: _________________

Incontinence: _________________

Arthritis: _______________________

History of stroke: ______________

History of seizure: ______________

History of head injury: ___________

History of cancer: ______________

Vision impairment: ___________________

Hearing loss: ________________________

Dizziness: _________________________

Additional Notes:

Please list major surgeries:

____

____

Do you drink alcohol? If so, how much:

Do you smoke? If so, how many packs a day and for how long?

Do you use other recreational drugs?

Have you ever had an EKG? ☐Y ☐N If yes, when? _________________
Have you ever had brain imaging? ☐Y ☐N If yes, when? _________________

PAST PSYCHIATRIC HISTORY:

1. Have you had prior Outpatient treatment: ☐Yes ☐No

Please list the reason, by whom and dates:

____

____

____

____

2. Have you ever been treated for:

Depression	ADHD	Bipolar Disorder
Anxiety	OCD	Schizophrenia
Panic Attacks	PTSD	Alcohol Problem
Anorexia/Bulimia	Binge eating	Drug Problem
ECT		

3 . Have you ever attempted to hurt yourself? ☐Yes ☐No

4. Psychiatric Hospitalizations: ☐Yes ☐No

Please list hospitalizations, reason, dates, and hospital:

____

____

____

____

5. Do you own firearms? ☐Yes ☐No

6. Please list any previous treatment you have had for alcohol or drug abuse (including rehabilitation programs, NA, AA, etc.)

____

____

7. How many caffeinated beverages do you drink in a day?

Coffee ____ Soda ______ Tea _______ Energy drink ______

DEVELOPMENTAL HISTORY

1. Where were you born? ____

2. Please list siblings and their ages:

____

____

____

3. Were your parents divorced?

4. How old were you when you left home?

TRAUMA HISTORY
Have you ever been verbally, physically, or sexually abused? ☐Y ☐N

____

____

EDUCATION:
Highest grade completed: _______________ Where? ____________________

Did you attend college? _________________ Where?____________________

Highest Degree achieved: ________________________

OCCUPATION:
1. Are you currently :
☐working ☐Unemployed ☐Disabled ☐Retired

2. How long in present position: ____

3. What is/was your occupation: ____

4. Have you ever served in the military? Yes ☐ No☐

RELATIONSHIPS
1. Are you currently:
☐Married ☐Partnered ☐Divorced ☐Single ☐Widowed
How long? __________

2. Any prior marriages? If so, how many? ____

3. How would you describe your sexual orientation?
☐Heterosexual ☐Homosexual ☐Bisexual ☐Transexual ☐Unsure

4. Do you have children? ____

HOME/DAY TO DAY:

1.Where do you live? (home, senior community, etc)

2. Who lives with you?

3. Do you need assistance with anything?

4. Do you have hobbies or other interests?

SPIRITUAL LIFE:

1. Do you belong to a particular spiritual group?

2. What is your level of involvement?

PLEASE CIRCLE IF YOU GET HELP MANAGING:

Bills

Medications

Cooking

Driving

Shopping

Housework

ANYTHING ELSE YOU WANT ME TO KNOW: