Medical and Mental Health Histories

Patient:_____ **Date of Birth:**_____

Psychiatric History

Are you concerned about the following? If yes, briefly explain.

Depression/Mood Elevation Symptoms ☐ No ☐ Yes_____

Anxiety Symptoms ☐ No ☐ Yes_____

Issues after a trauma ☐ No ☐ Yes_____

Eating Disorder Symptoms ☐ No ☐ Yes_____

Psychotic Symptoms (hallucinations) ☐ No ☐ Yes_____

ADHD (inattention/hyperactivity) Symptoms ☐ No ☐ Yes_____

Recent major stressors in your family (deaths, moves, marital changes, relationship issues, financial, legal, etc):

_____

What symptoms/situations brought you in to be evaluated today?

_____

_____

_____

_____

Have you received mental health treatment from a psychiatrist in the past?

☐ No ☐ Yes Name and date: _____

Name and date: _____

Have you received mental health treatment from a therapist or counselor in the past?

☐ No ☐ Yes Name and date: _____

Name and date: _____

Have you ever been hospitalized for a mental health disorder?

☐ No ☐ Yes Hospital and date: _____

Have you ever attempted to harm yourself in the past? (Suicide attempt, self harm i.e. cutting)

☐ No ☐ Yes (Please provide details)

_____

Have you been prescribed medications for a mental health disorder by a psychiatrist or other doctor in the past?

☐ No ☐ Yes (Medications):

Medication	Strength/Frequency	How long taken?	Prescribing doctor

Are you currently taking any medications prescribed by another doctor? ☐ No ☐ Yes

Medication	Strength/Frequency	How long taken?	Prescribing doctor

Have your previous psychiatric medications been helpful? Did you have any side effects? Why did you stop taking them?

Do you use any drugs, including alcohol, nicotine and/or illicit drugs? ☐ No ☐ Yes (Please provide details)

Have you ever used illicit drugs in the past? ☐ No ☐ Yes (Please provide details)

Past Medical History

Are you allergic (i.e., rashes, hives, anaphylaxis) to any medications? ☐ No ☐ Yes (drug and details of reaction)

Do you have any current health concerns? ☐ No ☐ Yes (Please provide details)

Have you ever been hospitalized overnight for any reason? □ No □ Yes (Please provide details and dates)

Have you had any major surgeries or accidents requiring medical treatment (fall, car accident, etc.) in the past?
□ No □ Yes (Please provide details and dates)

Have you ever hit your head so hard that you passed out or lost consciousness?
□ No □ Yes (Please provide details and dates)

Have you ever had a seizure? □ No □ Yes (details and dates)

Have you ever had chest pain or heart problems? □ No □ Yes (details and dates)

Have you ever passed out or fainted? p No p Yes (details and dates)

Are you currently sexually active? ☐ No ☐ Yes

Do you see a primary care physician (PCP), or any other doctor, on a regular basis?
(Please provide the physician's name, practice address, and phone number, if readily available)

Primary Care Physician:

Other Physician (i.e., Specialist physician):

General Information

Do you have any history of being physically, sexually, or emotionally abused? ☐ No ☐ Yes (Please provide details)

Do you have any history of witnessing traumatic events, including domestic violence? ☐ No ☐ Yes (Please provide details)

Were you ever placed in someone else's care other than that of your parents/guardians (i.e. social service removal)?
☐ No ☐ Yes (Please provide details)

Please list everyone currently living in your home (i.e., spouse, children, roommate)

What do you like to do in your free time (hobbies or other interests)?

Employer/School:

Highest grade level/degree attained:

History of Special or Regular Education?

Any history of repeating a grade(s)? ☐ No ☐ Yes (Please provide grade(s) repeated)

Any recent change in academic or work performance? ☐ No ☐ Yes (Please provide details)

Do you have any problems with friendships or relationships? ☐ No ☐ Yes (Please provide details)

Current relationship status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Do you have children (biological or adopted)? ? ☐ No ☐ Yes

If yes, how many and what are their ages, names, and sex (i.e., male or female)?

Family History

Do you have any history of blood-related family members (parents, grandparents, siblings, aunts/uncles, or immediate cousins) having a history of any of the following? (Please indicate whether the family member is on your mother's or father's side of the family)

Mood Disorders (i.e., Depression, Bipolar) ☐No ☐Yes [Family member(s)]

Anxiety Disorders (i.e., "Nervous Breakdowns") ☐No ☐Yes [Family member(s)]

Schizophrenia (i.e., Hallucinations) ☐No ☐Yes [Family member(s)]

Suicide Attempts or Completions pNo pYes [Family member(s)]

Drug Abuse or Dependence ☐No ☐Yes [Family member(s))

Alcohol Abuse or Dependence ☐No ☐Yes [Family member(s))

Learning Disorders/Mental Retardation ☐No ☐Yes [Family member(s))

ADHD or Behavioral Problems ☐No ☐Yes [Family member(s))

Sudden Death Before the Age of 40 years old ☐No ☐Yes [Family member(s))

Seizures ☐No ☐Yes [Family member(s))

Other (i.e., Autism) ☐No ☐Yes [Family member(s))

Thank you for completing this form.

Date: _____ **Patient Signature:** _____

Patient Name:_____

Circle all the symptoms that apply to you

MOOD
Sadness
Tearfulness
Feeling empty
Suicidal thoughts/attempts
Anxiety
Fear
Panic attacks
Irritability
Anger
Guilt
Social anxiety
Elevated mood
Mood swings
Self-harming (ex: cutting)

SLEEP
Problems falling asleep
Problems staying asleep
Waking in the early morning
Nightmares
Waking in panic
Sleeping too much
Sleeping too little

ENERGY
Too much
Too little

APPETITE/WEIGHT
Increased appetite
Decreased appetite
Increased weight
Decreased weight
Restrictive dieting
Over-exercising
Binge-eating
Purging
Taking laxatives

MOTIVATION/INTEREST
Little/no joy in pleasurable things
No drive to accomplish tasks

IMPULSIVITY
Impulsive spending
Putting self in danger
Interrupting others
Cannot wait your turn

CONCENTRATION/FOCUS
Cannot start/stick with/complete tasks
Difficulties concentrating on:
- School/homework
- Reading
- Conversations

Mind is racing
Procrastinating