

**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):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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?**

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

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

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**Past Medical History**

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

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

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**Have you ever been hospitalized overnight for any reason?** No Yes (Please provide details and dates)\_\_\_\_\_\_\_\_\_\_\_\_\_

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**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?**  No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)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Do you have any history of witnessing traumatic events, including domestic violence?**  NoYes (Please provide details)\_\_\_\_\_\_\_\_

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**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)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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**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)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**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)?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**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** No Yes [Family member(s)]\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Drug Abuse or Dependence** No Yes [Family member(s)]\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Alcohol Abuse or Dependence** No Yes [Family member(s)]\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Legal Issues (i.e., Incarcerations)** No Yes [Family member(s)]\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Learning Disorders/Mental Retardation** No Yes [Family member(s)]\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ADHD or Behavioral Problems** No Yes [Family member(s)]\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Childhood Cardiac Disease (i.e., Murmurs, Structural Defects)** 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)]\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Diabetes** No Yes [Family member(s)]\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Cholesterol Problems** 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

Tearfullness

Feeling emoty

Suicidal thoughts/attempts

Anxiety

Fear

Panic attacks

Irritability

Anger

Guilt

Social anxiety

Elevated mood

Mood swings

Self-harming (ex: cutting)

**SLEEP**

Problems fallng 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