Psychiatric History

Patient Name____DOB__________________________

Chief Complaint____

Marital Status: ☐ single ☐ married ☐ separated ☐ divorced ☐ unmarried, committed relationship ☐ widowed ☐ other

Living Arrangement: ☐ alone ☐ with family ☐ with relatives ☐ foster care ☐ board & Care ☐ nursing home

When did you first notice any signs and symptoms related to this problem? ____

Circle the behaviors that apply to you:

Anxiety
Depression
Impulsive act before thinking
Suicidal thought (specify)
Physical abuse
Sexual abuse
Violent thoughts
Too little or too much sleep
Excessive behaviors
(ex: sex, gambling, shopping, computer)
Poor appetite or over eating
Anorexia or binging/purging
Feeling hopeless
Fatigue/ loss of energy
Feeling of worthlessness/guilt
Difficulty concentrating
Difficulty making decisions
Lost temper easily or exploded
Housing/economic problems
Hard to control worrying

Destroyed property
Easily annoyed/irritated/ on edge
Distressing dreams/nightmares
Memory Problems/changes
Easily distracted/frustrated
Difficulty paying attention
Elevated or Hyper mood
Increased activity level
Talking excessively
Restless/agitated
Panic attacks
Dizziness
Chest pain or shortness of breath
Numbness or tingling sensation
Phobias or fears
Fear of dying
Obsessions or compulsions
Legal Problems
Hurting others(people/animals)
Easily startled

Avoid places/situations
Anger
Disorganized thoughts
Sexual concerns
Unusual perceptions
Paranoid/suspicious thoughts
Hallucinations
Weight loss or weight gain
Racing thoughts
Alcohol/drug problems
High –risk taking behaviors
Injuring or harming yourself
Relationship problems
Family Problems
Social support Problems
Work/school problems
Learning disabilities problems
Withdrawing/ social isolation
Started fight or argument
Delusions

Comments/ other information:

____

____

Have these interfered with your ability to function? ☐ emotionally ☐ physically ☐at home ☐ at work or school

Explain how ____

____

____

Counseling/Psychiatric Treatment History:

	No	Yes	When	Provider Name/ location	For how long?
Counseling/ Psychiatric treatment	☐	☐	__________	__________________________	__________
Suicidal Thoughts/ attempts	☐	☐	__________	__________________________	__________
Hospitalizations	☐	☐	__________	__________________________	__________
Were you abused as a child?	☐	☐	__________	__________________________	__________

Medical History:

What medications are you taking presently? (Name, Dose) ____

____
____
____
____
____

Do you have any known allergies to medication? ☐ No ☐Yes
(If so provide allergies and reactions to them) ____

____
____

Do you have history of Thyroid disease? ☐No ☐Yes

Do you have history of excessive hair loss/dry skin/feeling cold? ☐ No ☐Yes

Do you have any medical problems? (Describe) ____

____

If any list past surgeries, hospitalizations, serious injuries and head injuries:

____
____
____

Circle all that apply to you:

AIDS/HIV+	Cancer	Hepatitis	Sexually-transmitted diseases
Alcoholism	Childhood diseases	Liver Problems	Allergies
Chronic Pain	High Blood Pressure	Tuberculosis	Anemia
Diabetes	Kidney Problems	Thyroid Problems	Arthritis
Drug Abuse	Neurological Disorders	Vision Problems	Asthma
Epilepsy	Hearing Problems	Rheumatic Fever	Birth defects
Heart Problems	Stroke	Brain Injury	Headaches

Other (specify)____

Family History:

	Biological Family History	Adoptive/step/legal guardian medical history
Substance abuse	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown
Psychiatric Problems	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown
Had Thyroid Disease	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown
Abused Drugs or ETOH	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown

Developmental History:

Highest level of education completed? ____

Were you ever disruptive in class? ☐ No ☐Yes

Did anyone ever call you hyperactive? ☐ No ☐Yes

Are you currently enrolled in school? ☐ No ☐Yes

Social History:

Tobacco

☐ Current every day smoker
☐ Current some day smoker
☐ Light tobacco smoker
☐ Heavy tobacco smoker
☐ Never smoked
☐ Former smoker
☐ Smoker
☐ Current status unknown
☐ Unknown if ever smoked

Alcohol

☐ Do not drink ☐ Drink daily ☐ Frequently drink ☐ Hx of Alcoholism ☐ Occasional drink

Drug Abuse

☐ INDU ☐ Illicit drug use ☐ No illicit drug use

Cardiovascular

☐ Eat healthy meals ☐ Regular exercise ☐ Take daily aspirin

Safety

☐ Household smoke detector ☐ Keep Firearms in home ☐ Wear Seatbelts

Sexual Activity

☐ Exposure to STI ☐ Homosexual encounters ☐ Not sexually active ☐ Safe sex practices ☐ Sexually active

Birth Gender

☐ Male ☐ Female ☐ Undifferentiated

MENTAL HEALTH DISCLOSURE FORMS

DEPRESSION SCREEN

Over the last 2 weeks, how often have you been bothered by any of the following problems	**Not at All**	**Several Days**	**More than Half of the Days**	**Nearly Every Day**
Little interest or pleasure in doing things				
Feeling down, depressed or hopeless				
Trouble falling or staying asleep, or sleeping too much				
Feeling tired or having little energy				
Poor appetite or overeating				
Feeling bad about yourself, or that you are a failure or have let yourself or your family down				
Trouble concentrating on things, such as reading the newspaper or watching television				
Moving or speaking so slowly that other people could have noticed, or the opposite- being so fidgety or restless that you have been moving around a lot more than usual				
Thoughts that you would be better off dead or hurting yourself in some way				

TWO QUESTIONS ABOUT YOURSELF

	YES	**NO**
During the past month, have you often been bothered by feeling down, depressed or hopeless?		
During the past month, have you been bothered by feeling little interest or pleasure in doing things?		

ADULT ADHD Self Report Scale

Check the box that best describes how you have felt and conducted yourself over the past 6 months	**Never**	**Rarely**	**Sometimes**	**Often**	**Very Often**
How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
How often do you have difficulty getting things in order when you have to do a task that requires organization?					
How often do you have problems remembering appointments or obligations?					
When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
How often do you fidget or squirm with your hands or feet, when you have to sit down for a long time?					
How often do you feel overly active and compelled to do things, like you were driven by a motor?					

GENERALIZED ANXIETY DISORDER Scale

Over the <u>last 2 weeks</u> how often have you been bothered by the following problems?	**Not at All**	**Several Days**	**More than Half the Days**	**Nearly Every Day**
Feeling nervous, anxious or on edge				
Not been able to stop or control worrying				
Worrying too much about different things				
Trouble relaxing				
Being so restless that it is hard to sit still				
Becoming easily annoyed or irritable				
Feeling afraid as if something awful might happen				

MOOD QUESTIONNAIRE

Please check one box only for each of the questions below

1. Has there ever been a period of time when you were not your usual self and ……………	**YES**	**NO**
….you felt good or so hyper that other people thought you were not your normal self, or you were so hyper that you got into trouble?		
….you were so irritated that you shouted at other people or started fights or arguments?		
….you felt much more self confident than usual?		
….you got much less sleep than usual and found that you didn't really miss it?		
….you were much more talkative and /or spoke much faster than usual?		
….thoughts raced through your head and you could not slow your mind down?		
….you were so easily distracted by things around you that you had trouble concentrating or staying on track?		
….you had much more energy than usual?		
….you were much more active and/or did many more things than usual		
….you were much more social or outgoing than usual for example, you telephoned friends in the middle of the night?		
….you were much more interested in sex than usual?		
….you did things that were unusual for you or that other people might have thought were excessive, foolish or risky?		
….spending money got you or your family into trouble?		
2. If you have checked YES to more than one of the above, have you experienced several of these during the same period of time?		

3. How much of a problem did any of these situations cause you like being unable to work, having family, money or legal problems, and/or getting into serious arguments or fights?

☐ No Problem ☐ Minor Problem ☐ Moderate Problem ☐ Serious Problem