Behavioral Health Associates

Name: _____ Date: _____

Date of Birth: _____

Primary Care Physician: _____

Current Therapist/Counselor: _____

Who may we thank for this referral? _____

What is the main reason for coming in today? _____

_____

_____

How long has the problem or pattern existed? _____

_____

_____

Under what conditions does the problem or pattern usually get worse? _____

_____

_____

Under what conditions does the problem or pattern usually improve? _____

_____

_____

What would you like to see change by coming here? _____

_____

_____

Please check all that you feel apply:

- ○ Depressed mood
- ○ Unable to enjoy activities
- ○ Sleep pattern disturbance
- ○ Loss of interest
- ○ Depressed Mood
- ○ Change in appetite
- ○ Increased irritability
- ○ Decreased libido
- ○ Racing thoughts
- ○ Impulsive behavior
- ○ Increase risky behavior
- ○ Increased libido
- ○ Decreased need for sleep
- ○ Excessive energy
- ○ Fatigue
- ○ Anxiety attacks
- ○ Avoidance
- ○ Hallucinations
- ○ Suspiciousness
- ○ Excessive guilt
- ○ Crying spells
- ○ _____

Are you experiencing ***significant changes, loss or difficulties*** in the following areas? (Yes, No, Unsure)

Financial	Y	N	U
Primary relationship (family/friends)	Y	N	U
Housing	Y	N	U
Physical health of self or family member	Y	N	U
Access to health care	Y	N	U
Occupation/employment	Y	N	U
Legal	Y	N	U
Education	Y	N	U
Other: _____	Y	N	U

Psychiatric History

Have you ever been given a psychiatric diagnosis?

No _____ Yes (describe) _____

Have you ever had psychotherapy or counseling in the past?

No _____ Yes (describe) _____

Have you ever seen a psychiatrist before?

No _____ Yes (describe) _____

Outpatient Treatment: _____ No _____Yes, if yes, please describe when, by whom and the nature of treatment.

Reason Date Treated By Whom

_____

_____

Psychiatric Hospitalization: _____ No _____Yes, if yes, please describe when, by whom and the nature of treatment.

Reason Date Hospitalized Where

_____

_____

Did you observe abuse of any family member in your family of origin?	Y	N	U
Were you abused/neglected in your family of origin?	Y	N	U
Outside your family of origin, have you experienced abuse?	Y	N	U

Circle type of abuse: sexual abuse physical abuse emotional abuse / harassment

Education and Work History

Education

Last school grade completed: _____

Years of college: _____ Degree(s): _____ Year(s): _____

Are you currently enrolled in school? ☐Yes ☐No

If yes, what is your major/focus? _____

Spouse/Partners education: Last grade completed:_____ Year:_____ Degree:_____

Employment

Check all that apply:

☐Employed ☐Homemaker ☐Student ☐Disabled* ☐Unemployed* ☐Retired

Current Employer: _____

What are your duties at your job? _____

Years on current job: _____

If you checked disabled or unemployed, are you on: ☐Medical Leave ☐Workers Compensation

Last day worked: _____ Physician you see for work-related problems: _____

What jobs have you held in the past?

Position	Duration	Satisfaction Lo=1...Hi=5	Reason for Leaving

Military History

Did you serve in the military? ☐Yes ☐No

If yes, describe if voluntary/draftee, combat experience if any, awards received, disciplinary actions if any, discharge status, injury while in service if any and any other major events:

_____

_____

Legal Status

Have you ever been involved with the Police or the Courts? ☐Yes ☐No If yes, please explain:

Reason for Involvement	Date	Outcome	Was this related to alcohol/drug use?

Lifestyle and Family History

Family Background and Childhood History:

Where did you grow up? _____ Were you adopted? ☐Yes ☐No

If you have siblings, list their ages: _____

What was your father's occupation? _____

What was your mother's occupation? _____

Did your parents divorce? ☐Yes ☐No If so, how old were you when they divorced? _____

If your parents divorced, who did you live with? _____

Describe your father and your relationship with him: _____

_____

Describe your mother and your relationship with her: _____

_____

How old were you when you left home? _____

Has anyone in your immediate family passed away? _____

Who and when? _____

Were there any complications (premature birth, major medical problems) at your birth? ☐Yes ☐No

Please describe: _____

Any problems in your early development (learning to walk, talk, etc)? ☐Yes ☐No

Please describe: _____

Did you suffer from any major illnesses/injuries while you were growing up? ☐Yes ☐No

Please describe: _____

Marital Status:

- ○ Single, never married
- ○ Engaged _____ months
- ○ Married for _____ years
- ○ Divorced for _____ years
- ○ Separated for _____ years
- ○ Divorce in process _____ months
- ○ Live-in for _____ years
- ○ _____ Prior Marriages (self)
- ○ _____ Prior Marriages (partner)

Intimate relationship:

- ○ Never been in a serious relationship
- ○ Not currently in a relationship
- ○ Currently in a serious relationship

Relationship satisfaction:

- ○ Very satisfied with relationship
- ○ Satisfied with relationship
- ○ Somewhat satisfied with relationship
- ○ Dissatisfied with relationship
- ○ Very dissatisfied with relationship

List all persons currently living in patient's household:

Name	Age	Sex	Relationship to Patient

List children <u>not</u> living in the same household as patient:

Name	Age	Sex	Relationship to Patient

Your Exercise Level:

Do you exercise regularly? ☐Yes ☐No

How many days a week do you get exercise? _____

How much time each day do you exercise? _____

What kind of exercise do you do? _____

What are some things you enjoy doing (hobbies, sports, past times)? _____

_____

Spiritual/Religious Interests

If spirituality, religion or a higher power is an important part of your life:

Are you part of a spiritual or religious community? ☐Yes ☐No

Optional: What denomination or affiliation: _____

Do you want your therapist/physician to take your spiritual or religious outlook into consideration in planning your care? ☐Yes ☐No

If yes, please describe or give examples: _____

Family Psychiatric History Check all that apply:

	Father	Mother	Father's Father	Father's Mother	Mother's Father	Mother's Mother	Siblings	Children	Mothers' Relatives	Fathers' Relatives
Developmental Disorder										
Reading Disorder										
Math Disorder										
Autistic Spectrum Disorder										
Autism										
Asperger's										
ADHD										
Concentration problems										
Hyperactivity										
Tourettes										
Dementia										
Alzheimer's										
Eating Disorder										
Anorexia										
Bulimia										
Substance Abuse										
Alcoholism										
Mood Disorder										
Major Depression										
Bipolar Disorder										
Mania										
Psychotic Disorder										

Family Psychiatric History (cont.) Check all that apply:

	Father	Mother	Father's Father	Father's Mother	Mother's Father	Mother's Mother	Siblings	Children	Mothers' Relatives	Fathers' Relatives
Schizophrenia										
Anxiety Disorder										
Generalized Anxiety										
Panic Disorder										
Agoraphobia										
Nervous Breakdown										
Obsessive Compulsive Disorder										
Obsessive Thinking/Worrying										
Compulsions										
Phobias										
Postraumatic Stress Disorder										

Family Medical History Check all that apply:

	Father	Mother	Father's Father	Father's Mother	Mother's Father	Mother's Mother	Siblings	Children	Mothers' Relatives	Fathers' Relatives
High Blood Pressure										
Seizures/Epilepsy										
Cancer										
Heart Attack										
Stroke										
Diabetes										
Asthma										
Movement Disorders										
Tics (motor or verbal)										
Other Neurological Disorders										
Migraine										
Immunologic Disorder										
Thyroid Disease										
Anemia										
Liver Disease										
Chronic Fatigue										
Kidney Disease										
Asthma/respiratory problems										
Stomach or intestinal problems										
Fibromyalgia										
Heart Disease										
Chronic Pain										

Family Medical History (cont.) Check all that apply:

	Father	Mother	Father's Father	Father's Mother	Mother's Father	Mother's Mother	Siblings	Children	Mothers' Relatives	Fathers' Relatives
High Cholesterol										
Head Trauma										
Liver Problems										
Glaucoma										
Heart Surgery										
Hormone Problems										
Sexually Transmitted Disease										
HIV										
Other										

Medical History

Your Medical History:

Allergies to Medications: _____

Other Allergies: _____

List any Medical Problems (Example: High blood pressure, Diabetes, Etc.): _____

_____

_____

_____

List any medical or psychiatric hospitalizations: _____

_____

_____

_____

Past Surgeries: _____

_____

_____

_____

Past History of Head Trauma (please specify): _____

_____

_____

Do you have any concerns about your physical health that you would like to discuss with me? ☐Yes ☐No

Date and place of your last physical exam: _____

For Women Only: Date of last menstrual period: _____ Are you currently pregnant or do you think you might be pregnant? ☐Yes ☐No Are you planning on trying to get pregnant in the near future? ☐Yes ☐No

Birth control method: _____

How many times have you been pregnant? _____ How many live births? _____

Drug and Alcohol History

Caffeine

Do you drink coffee or other caffeinated beverages? ☐Yes ☐No

Number of cups or 8oz. servings per day: _____ Type of Beverage: _____

Cigarettes/Tobacco

Do you currently smoke or chew? ☐Yes ☐No

If yes: Number of years: _____ Number of packs per day: _____

How long has it been since your last cigarette? _____

If you don't currently chew have you in the past? ☐Yes ☐No

Alcohol

Do you currently drink alcohol or have you within the past year? ☐Yes ☐No

How long have you been drinking? _____ What type of beverage? _____

How many times per week? _____ Average amount consumed each week? _____

If not currently drinking, have you consumed alcohol in the past? ☐Yes ☐No

Current Drug History

Do you use drugs or illicit substances currently/past year? ☐Yes ☐No

Type: _____

How much, how long, how often? _____

If not currently drinking, have you consumed alcohol in the past? ☐Yes ☐No

Past Drug History

Have you used drugs in the past? ☐Yes ☐No Type: _____

How much, how long, how often? _____

How long since last use? _____

Do you participate in any programs for remaining clean and sober? ☐Yes ☐No

If yes, please identify programs: _____

Are you currently involved in a recovery program? ☐Yes ☐No

If yes, please describe:

If there is anything else significant you believe I need to know at the start of your treatment, please list it below: