MINDS *that* MATTER

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ADULT PATIENT INFORMATION FORM

IDENTIFYING INFORMATION Date Completed: _____

Name (Please Print): _____ Nickname: _____

SSN: _____ Date of Birth: _____ Age: _____

Gender: _____ Ethnicity: _____

Address: _____
Street (Apt. No.) City State Zip

Phone Numbers: Home/Cell _____ Work _____

Best number to reach you: _____

Best number to leave a message: _____

Email address: _____

Marital Status: ___ Single ___ Married ___ Partnered ___ Separated ___ Divorced ___ Widowed

Living with spouse/partner? ____ Yes ____ No Number of years together _____

Employer/School _____

Occupation _____

Highest Level of Education _____

Children? ____ Yes ____ No Ages of kids _____ (Please circle ages of kids living in home)

Emergency Contact(s):

(1) Name: _____ Phone Number: _____

(2) Name: _____ Phone Number: _____

REASONS FOR EVALUATION

Who referred you to this clinic? _____

Please state your concerns; specify nature of problem, onset, duration, frequency, and severity:
_____
_____
_____
_____
_____
_____
_____
_____

Did a specific event lead to this request for evaluation/treatment? _____ Yes _____ No If so, please describe:
_____
_____
_____
_____

Are you undergoing any unusual stressors? _____
_____
_____

What are your goals for treatment? _____
_____
_____
_____
_____

SOCIAL-BEHAVIORAL AND PSYCHIATRIC HISTORY

List all past outpatient psychiatric/psychological/mental health services:
_____ None reported _____ Unknown

Provider Name(s):	**Dates of tx:**	**Services provided:**	**Outcomes:**	**Termination reason(s):**

List any history of psychiatric hospitalization and/or residential treatment:
_____ None reported _____ Unknown

Provider Name(s):	**Dates of tx:**	**Services provided:**	**Outcomes:**	**Discharge status:**

Psychiatric medication history:

Current	**Past**	**Name of medication(s):**	**Condition(s):**	**Prescribing MD:**	**Dose/Schedule:**	**Response/side effects:**

MEDICAL/PHYSICAL HISTORY

Who is your primary doctor? _____ Phone: _____

Address: _____

History of serious and/or chronic illness: _____

Sleep problems: _____
Have you had any history of seizures or head injury? _____ Yes _____ No (If yes, specify type, duration, frequency and date of last EEG) _____
_____
_____

Have you had a history of serious injuries/accidents or episodes with loss of consciousness?
_____ Yes _____ No (If yes, please provide dates and details): _____
_____

History of medical hospitalizations and/or surgeries: _____ None reported _____ Unknown

Medication allergies (include type of reaction): _____

Current ongoing use of medications for physical health: _____ None reported _____ Unknown

Name of medication(s):	**Condition(s):**	**Prescribing Physician:**	**Dose/Schedule:**	**Response/Side Effects:**

Homeopathic, naturopathic, herbal and/or other alternative medicine treatments for physical health:
_____ None reported _____ Unknown

Current	**Past**	**Name of treatment:**	**Condition(s):**	**Prescribing MD:**	**Response/side effects:**

Symptoms	**Current**	**Past**
Headaches		
Dizziness		
Stomach/bowel trouble		
Health problems		
Pain		
Tremors or tics		
Drug/alcohol cravings		
Eating problems		
Binge eating		
Sleep problems		
Symptoms	**Current**	**Past**
Weight gain		
Weight loss		
Loss of appetite		
Low energy		
Feeling worthless		
Memory problems		
Thoughts of suicide		
Planning suicide		
Suicide attempt		
Feeling depressed		
Crying a lot		
Unable to have a good time		

Restlessness		
Decreased need for sleep		
Mood swings		
Excess energy		
Confusion		
Elated/euphoric mood		
Excessive spending		
Racing thoughts		
Irritability		
Impulsive behavior		
Grandiose thoughts/plans		
Anger or explosiveness		
Panic attacks		
Anxiety		
Fears		
Nightmares		
Fears of losing self control		
Recurring & unwanted thoughts or behaviors		
Self injuring		
Always worrying		
Concentration problems		
Hearing voices		
Seeing things other's don't		
Strange experiences		
Feel people plot against you		
Constant suspicion/distrust		
Unusual thoughts		
Violent aggressive behavior		
Thoughts of physically harming someone		
Physical abuse		
Sexual abuse		

Sexual problems		
Relationship problems		
Financial problems		
Work problems		
Social withdrawal		
Conflict in family		

LEGAL HISTORY

History of law breaking behavior? _____ Yes _____ No (Provide details about history of arrest, detention, gang involvement, diversion, etc): _____
_____
_____
_____

SOCIAL HISTORY

Educational history: _____

Occupational history/employment status: _____

SUBSTANCE ABUSE HISTORY

Past use of: _____ cigarettes _____ alcohol _____ drugs _____ no use
Current use of: _____ cigarettes _____ alcohol _____ drugs _____ no use

Previous substance treatment programs:

Dates	**Location**	**Did you complete program?**

FAMILY MEDICAL HISTORY

Does anyone in your family have any of the following conditions? Check all that apply, past or present:

Condition/Circumstance	Patient	Mother	Father	Sibling	Mother's Family	Father's Family
Mental Retardation						
Learning Disorder						
Attention Deficit						
Hyperactivity						
Epilepsy						
Neurological Disorders						
Alcohol Abuse						
Drug Abuse						
Physical/Emotional Abuse						
Sexual Abuse						
Depression						
Suicide Attempts						
Anxiety Disorders						
Specific Fears or Phobias						
Panic Attacks						
Schizophrenia						
Visual disability/Problems						
Deaf/Hard of Hearing						
Tics/Tourette's Syndrome						
Chronic Illnesses						
Homelessness						
Teen Pregnancy						
School Suspension/Expulsion						
Special Education						
Birth Defects						
Miscarriages						
Other: _____						

Is there any family conflict currently in the household in which you reside? _____ Yes _____ No