

## Ilardi Psychiatric Services

Please complete the following confidential patient information form and return to Maria Ilardi during your initial evaluation. This information about your medical history and background will be useful in the evaluation and treatment process.

### Check any of the following chronic medical conditions that you currently experience:

- |   |  |
|---|--|
| <input type="checkbox"/> Anemia         | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Asthma         | <input type="checkbox"/> High Cholesterol    |
| <input type="checkbox"/> Cancer         | <input type="checkbox"/> Seizures            |
| <input type="checkbox"/> Diabetes       | <input type="checkbox"/> Strokes             |
| <input type="checkbox"/> Glaucoma       | <input type="checkbox"/> Thyroid Problems    |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Hepatitis           |

### List any other medical problems you have:

---

---

---

### List any surgeries or hospitalizations you've had, along with the reason for surgery/hospitalization and date of the event:

---

---

### List any significant head injuries (concussion, being knocked out, brain damage, etc.)

---

**Are you pregnant?** Yes / No    **Nursing?** Yes / No

**Planning to become Pregnant?** Yes / No

**Do you use Birth control?** Yes / No

**Do you have disordered eating (binging, purging, restricting, excessive use of laxatives or exercise)?** Yes / No

### List any current medications, over-the-counter drugs, and supplements you take :

<u>Name of drug</u>	<u>Strength</u>	<u>Frequency taken</u>
---------------------	-----------------	------------------------

---

---

---

---

---

**Allergies/Adverse reactions to medications:**

<u>Name of drug</u>	<u>Reaction you had</u>
_____	_____
_____	_____

**List all psychiatric medications you have taken in the past (not current):**

<u>Date taken</u>	<u>Medication/dose/frequency</u>	<u>Effectiveness</u>	<u>Side Effects</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Exercise:**

- \_\_\_ Sedentary (no regular exercise)
- \_\_\_ Mild exercise (e.g., regularly climb stairs, do yard work, short walks, etc.)
- \_\_\_ Occasional vigorous exercise (less than 3 times per week for 30 min)
- \_\_\_ Regular vigorous exercise (3 times a week for 30 min. or more)

**Substance Use History:**

Amount typically consumed:

Caffeine (cups/day) \_\_\_\_\_

Cigarettes/Tobacco \_\_\_\_\_

Alcohol \_\_\_\_\_

**Have you ever abused drugs or alcohol?** Yes / No

**If yes, please describe:**

<u>Substances</u>	<u>Amount</u>	<u>Frequency</u>	<u>When (first use, last use)</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever received substance abuse treatment of any kind? Yes / No

Do you have a history of black outs, seizures, withdrawal symptoms? Yes / No

Have you ever felt you should cut down drinking/ drug use? Yes / No

Have people annoyed you by criticizing your drinking/drug use? Yes / No

Have you ever felt bad or guilty about your drinking/drug use? Yes/ No

Have you ever drank/used drugs in the morning to steady your nerves or relieve a hangover?  
Yes/ No

Are you prone to binge drinking? Yes / No

**Social History (please check one):**

**Marital Status:** \_\_ single \_\_domestic partner \_\_ married \_\_ separated\_\_divorced \_\_widowed  
**Number of marriages**\_\_\_\_\_

**Children:** Yes/ No **Names and ages:** \_\_\_\_\_

**Who lives in your current household?** \_\_\_\_\_

**Who did you live with growing up (i.e.: parents, siblings, grandparents, foster homes)?**  
\_\_\_\_\_  
\_\_\_\_\_

**Where did you grow up?**\_\_\_\_\_

**Education:** Years completed\_\_\_\_\_ Highest degree obtained\_\_\_\_\_

**Did you have any behavior or learning problems in school?**\_\_\_\_\_

**Are you currently employed?** Yes / No

**If no, how long have you been unemployed?** \_\_\_\_\_

**If yes, what is your current occupation/employer?**\_\_\_\_\_

**Have you had any work related problems?** \_\_\_\_\_

**Briefly describe your employment history for the past 5 years:**  
\_\_\_\_\_  
\_\_\_\_\_

**Please describe any religious affiliation or spiritual practices:**\_\_\_\_\_

**Have you ever been arrested or convicted of a crime?** Yes / No