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History and Presenting Problem

Name______________________________ **Date of Birth**_________ **Sex** ☐ Male ☐ Female **Today's Date** _______________
Last, First Middle mm/dd/yyyy mm/dd/yyyy

For what reason(s) are you seeking services from our office?

What is the duration of these symptoms? **(How long? Has the intensity varied?)**

Have you seen a counselor or psychologist before? **YES** **NO** If **Yes**, please complete the questions below.

Name of Dr/Therapists	Appointment Frequency	How long since last appt.?	Reason(s) you were being seen.	Outcome/Did it help?
				Yes No
				Yes No
				Yes No

DEVELOPMENT and EDUCATION

When your mother was pregnant with you, were there any complications during the pregnancy or birth? YES NO
If yes, please describe.

Do you have any history of any of the following conditions? (please check all that apply)

Head Injury High Fever Chronic Medical Illness Prenatal exposure to toxins (drugs &/or alcohol)

Please give additional information related to the ones you checked.

Please select the highest level of education you have completed:

Graduate Degree Bachelor's Degree Some college or technical school High School Graduate/GED Some high school

How would you describe your educational experience? (please check all that apply)

Enjoyable/I love to learn Very stressful Didn't have any friends I was always bored

I struggled learning I learned best in "hands-on" classes I only enjoyed the social part of school

Have you had any legal issues specifically related to your conduct or behavior? (past or present) YES NO
If yes, please explain:

MEDICAL and PSYCHIATRIC

Primary Care Physician____________________________________**Office Phone Number**________________

Current health conditions:

Previous Medical or Psychiatric Diagnoses:

Select the words that best apply:

Handedness: Right Left Ambidextrous

Appetite: Good Poor Fair Intense

Weight: Stable Loss Gain Binging Binging/Purging

Thought Processing: Racing Pressured Intrusive Obsessive Non-pressured

Predominant Mood(s): (Pick all that apply) Anxious Depressed Happy Sad Fearful Manic Just so-so Flat Other

In the past six months, which of the following have you experienced? (Pick all that apply)

Moderate Exercise Inability to have fun Pleasurable Activities Stable, enjoyable sex life Diminished interest in activities Pre-occupation with pleasurable activities

SLEEP: Average Number of hours/night: _______ **Quality of Sleep:** Restful Unrestful

Waking up while sleeping: Frequent Infrequent Very Frequent Insomnia Early Waking Mid-sleep disruption

Frequent experience of: Nightmares Night terrors Recurrent dreams

How would you rate your sleep disturbance? Minor Not an issue Moderate Significant Serious

Current Symptoms---Rate the items with which you are currently having problems. Select the number that best indicates the severity of the problem.

0=None 1=Minor 2=Moderate 3=Significant 4=Serious

Thoughts of Self-harm		Anxiety-Worry		Anxiety-Fear	
Anxiety-Panic		Anxiety-Phobia		Feelings of Depression	
Feelings of Sadness		Thoughts of Death		Thoughts of Suicide	
Mood Swings		Grief over a major loss		Grief over the death of a loved one	
Abuse-Emotional		Abuse-Physical		Abuse-Domestic	
Abuse-Ritual		Sexual Abuse-Rape		Sexual Abuse-Incest	
Feelings of Despair		Memory-Forgetfulness		Memory-Changes	
Marriage Problems		Relationship problems with children		Problems with Parents	
Problems with Family		Problems with Work/School		Legal problems	
Problems with Alcohol		Problems with Drugs		Problems with Smoking	
Problems with other substances		Feelings of Hopelessness		Feelings of Helplessness	
Sexual concerns		Sexual problems			

MEDICATION REPORT

Current Medications

Name	Total Daily Dosage	Start Date	End Date	Reason for taking	Response/Side Effects

Current Supplements and/or Vitamins (including over the counter)

Name	Total Daily Dosage	Start Date	End Date	Reason for taking	Response/Side Effects

Past Medications

It is very helpful to know of past medications taken and how they affected you.

(If you don't remember exact information, please provide the best information you can.)

Medication Type:- SSRI's

Name	Total Daily Dosage	Start Date	End Date	Effective?	Side Effect(s)
Celexa (citalopram)					
Lexapro (escitalopram)					
Luvox (fluvoxamine)					
Paxil, Paxil CR, (paroxetine, paroxetine CR)					
Prozac (fluoxetine)					
Trintellix (vortioxetine)					
Viibryd (vilazodone)					
Zoloft (sertraline)					

Medication Type:- SNRI's

Name	Total Daily Dosage	Start Date	End Date	Effective?	Side Effect(s)
Cymbalta (duloxetine)					
Effexor (incl. IR & XR) (venlafaxine)					
Pristiq (desvenlafaxine)					
Strattera (atomoxetine)					

Medication Type:- Augmented

Name	Total Daily Dosage	Start Date	End Date	Effective?	Side Effect(s)
Abilify (aripiprazole)					
Depakote (divalproex)					
Geodon (ziprasidone)					
Invega (paliperidone)					
Neurontin (gabapentin)					
Risperdal (risperidone)					
Saphris (asenapine)					
Seroquel (quetiapine)					
Zyprexa (olanzapine)					

MEDICATION REPORT-Cont.

Medication Type:- Stimulants

Name	Total Daily Dosage	Start Date	End Date	Effective?	Side Effect(s)
Adderall (d/l amphetamine)					
Dexadrine (d-amphetamine)					
Intuniv/Tunix (guanfacine)					
Ritalin (methylphenidate)					

Medication Type:- TCA/Tetracyclic

Name	Total Daily Dosage	Start Date	End Date	Effective?	Side Effect(s)
Anafranil (clomipramine)					
Elavil, Endep (amitriptyline)					
Ludiomil (maprotilene)					
Merital (nomifensine)					
Norpramin, Pertofrane (desipramine)					
Pamelor, Aventyl (nortriptyline)					
Sinequan (doxepin)					
Surmontil (trimipramine)					
Tofranil (imipramine)					
Vivactil (protriptyline)					

Medication Type:- MAOI

Name	Total Daily Dosage	Start Date	End Date	Effective?	Side Effect(s)
Eldepryl (Selegine)					
Ensam (Selegine patch)					
Nardil (phenelzine)					
Marplan (isocarboxazid)					
Parnate (tranylcypromine)					

Medication Type:- Hormone Replacement

Name	Total Daily Dosage	Start Date	End Date	Effective?	Side Effect(s)
Estrogen Hormone					
Progesterone Hormone					
Testosterone Hormone					
Thyroid Hormone					

Medication Type:- Other

Name	Total Daily Dosage	Start Date	End Date	Effective?	Side Effect(s)
Ativan (lorazepam)					
Buspar (buspirone)					
Catapres (clonidine)					
Desyrel (trazodone)					
Lithium (Carbonate)					
Mellaril (thioridazie)					
Minipress (prazocin)					
Remeron (mirtazapine)					
Serzone (nefazodone)					
Valium (diazepam)					
Wellbutrin (buproprion)					
VNS					
Light Box					

FAMILY MEDICAL HISTORY

Did your parent(s) have a history of alcohol or drug abuse? **Yes** **No** If yes, please explain below.

Has anyone in your family been diagnosed with or treated for:

Condition	What relative(s)?	Condition	What relative(s)?
Anxiety		Depression	
Anger		Schizophrenia	
Bipolar Disorder		Post-traumatic Stress	

PERSONAL HISTORY

Do you have a history of Self-Harm? Yes No If yes, please explain

Do you have a history of physical, sexual, or emotional abuse? Yes No If yes, please explain

Do you have a history of alcohol and drug use? Yes No If yes, please explain

Have you been hospitalized for psychiatric reasons? Yes No If yes, please explain

PERSONAL INTERESTS

List hobbies and leisure interests

List individual strengths/positives

Who do you have for a personal support system?

This form was completed by:____

Relationship to patient: Self Spouse Parent Sibling Other