General Psychiatry

PATIENT'S NAME: _____ DATE: _____

Accompanied By: _____ Relationship: _____

SPECIFIC PRESENT CONCERNS:

DEPRESSION:	**Staff Use Only:**
Do You: — *Do You Have:* □ Often Get Angry — □ Decreased energy or fatigue □ Sleep too much/difficulty sleeping — □ Decrease or Increase in appetite □ Feel hopeless or helpless — □ Poor concentration □ Often feel sad/cry — □ Loss of interest in activities □ Feel excessively guilty — □ Loss of sexual interest □ Restlessness or irritability Which interferes with functioning □ None of these	
SUICIDALITY: Have you become obviously withdrawn/isolated? □ No □ Yes Are you having suicidal thoughts? □ No □ Yes Is there a plan? □ No □ Yes Is there a means to carry out this plan? □ No □ Yes What has or what could prevent you from acting on plan? Any suicidal thoughts in the past? □ No □ Yes If yes, what did you do? Have you ever heard voices telling you to harm yourself? □ No □ Yes Have you ever injured yourself on purpose? □ No □ Yes Have you had any suicidal attempts or actual suicides by family or friends? □ No □ Yes Specify:	
BEHAVIORS: Are you overly aggressive/destructive/argumentative or defiant? □ No □ Yes List any injuries to self or others that resulted from above behavior: Any thought/threats/plans to harm others? □ No □ Yes If yes, describe frequency and intensity of the thoughts: _____ Is there any plan/means to carry out plan? □ No □ Yes If yes, who is the individual(s) at risk? Have you made any verbal threats to anyone in the past 2 weeks? □ No □ Yes If yes, describe: _____ Have you ever repeated threats to someone? □ No □ Yes Do you have any difficulty with hyperactivity/impulsivity or paying attention? □ No □ Yes	
COGNITIVE: *Are you experiencing thoughts that:* □ Are racing — □ Someone is controlling you □ Are paranoid/suspicious — □ Are scattered with inability to focus on one idea *Are You:* □ Forgetful — □ Frequently losing things □ Seeing/hearing things that aren't real? Explain: _____ □ None of these	
ANXIETY: *Are you:*	**Staff Use Only:**

□Fearful, afraid
□ Nervous/Shaky
□ Perfectionist
□ Restless, cannot relax
□ An uncontrollable worrier
□ None of these
□ Withdrawn/avoiding leaving home
□ Biting your nails/plucking your hair
□ Thinking repetitive thoughts
□ Performing repetitive behaviors
□ Fearful of or are avoiding social situations

TRAUMA SYMPTOMS:

Have you ever witnessed or experienced a traumatic event (including emotional, physical, or sexual abuse)? □ No □ Yes

If yes, explain: _____

If yes, have any of the following been experienced/exhibited:

□ Nightmares
□ Super alertness to danger
□ Constant thoughts of trauma
□ Increase in addictive/compulsive behavior
□ Overreacting, startle easily
□ Flashbacks
□ Avoiding any reminders of event
□ Sexually abusive behavior towards others
□ Physically abusive behavior toward others
□ Difficulty feeling or expressing feelings
□ Difficulty imagining the future

EATING HISTORY:

Are You:

□ A picky eater
□ Compulsively overeating
□ Unduly fearful of becoming fat
□ Preoccupied with food
□ Binging on food
□ Seeing yourself as fat
□ Preoccupied with appearance
□ None of these
□ Compulsively exercising
□ Fasting to control weight
□ Vomiting to control weight
□ Using laxatives to control weight
□ Having irregular or absent menstrual periods
□ Having extreme changes in weight
□ A vegetarian

SLEEP:

Are You:

□ Unable to sleep
□ Having difficulty falling asleep
Time it takes to fall asleep: _____
□ Experiencing restless sleep/awakening frequently
□ Taking frequent naps
□ Snoring or snorting in your sleep
□ Grinding your teeth while sleeping
□ Having recurrent nightmares

Duration of problems: _____

Aids used to promote sleep: _____

How many hours of sleep in a 24 hour period: _____

Upon awakening are you:

□ Groggy □ Rested □ Other: _____

ADDICTIVE SYMPTOMS:

Have you ever used alcohol or drugs? □ No □ Yes

If yes, have you ever:

□ Lost control when intoxicated
□ Blamed others for use
□ Sexually acted out
□ Over used prescription medication
□ Lost friends due to use
□ Had job affected
□ Had gambling problems
□ Stolen from others
□ Smoked drugs
□ Sniffed glue/aerosol cans/gasoline/household cleaners
□ Lost reputation due to use
□ Felt you should cut down on use of alcohol and/or drugs
□ Felt annoyed when people criticized drinking/drug use
□ Felt guilty about drinking/drug use
□ Felt that others close to you wished you would cut down on your use
□ Had a drink upon awakening □ Daily □2-3 times weekly

FAMILY MENTAL HEALTH:

Have any of your relatives been treated for or taken medicine for mental health or a nervous?

□ No □ Yes

Staff Use Only:

(Check any illnesses that apply and identify the person's relationship to yourself):
M=Mother F=Father S=Sister B=Brother GM=Grandmother GF=Grandfather O=Other

□ Depression/ always sad _____
□ Manic depression/mood swings _____
□ Anxiety/Nervousness _____
□ Panic Disorder _____
□ Suicide _____
□ Schizophrenia _____
□ Usually Fearful _____
□ Substance Abuse _____
□ Learning Disorder _____
□ Seeing a therapist _____
□ Dementia/very confused _____
□ Sexual Disorders _____
□ Hearing Voices _____
□ Alcoholism _____
□ Anorexia _____
□ Obsessive/Compulsive _____
□ Homicide _____
□ Hyperactive _____
□ Seeing a psychiatrist _____

LEGAL:

Have you had:

- Any charges or legal offenses (DUI, DWI, PI, felonies/misdemeanors)? □ No □ Yes

If yes, specify dates _____/_____/_____

- Specify charge(s) and outcome if went to court: _____

_____

- Violent Offenses? □ No □ Yes

Explain _____

- Current legal charges pending? □ No □ Yes

If yes, specify charges _____

Name of Probation Officer _____

- Is treatment a result of your legal problems? □ No □ Yes

If yes, specify _____

- Any lawsuits, divorces, or custody issues in process or being initiated? □ No □ Yes

If yes, specify _____

PAST TREATMENT HISTORY:

- Have you had psychiatric/substance abuse treatment in the past? □ No □ Yes

□ Inpatient Treatment □ Outpatient Treatment □ Residential □ Day Treatment

- What were you treated for _____

Clinic/Facility/Clinician _____ Date _____/_____
Clinic/Facility/Clinician _____ Date _____/_____
Clinic/Facility/Clinician _____ Date _____/_____
Clinic/Facility/Clinician _____ Date _____/_____

- Did you follow up with treatment recommendations? □ No □ Yes

If no, explain why _____

_____

- Was treatment helpful? □ No □ Yes
- Were there any medications prescribed? □ No □ Yes

If yes, list _____

_____

_____

- Previous evaluations (psychological, educational, neurological)? □ No □ Yes

If yes, specify type and date _____

_____

_____

- Was family therapy included in treatment? □ No □ Yes
- Was group therapy included in treatment? □ No □ Yes

● Do you feel you fully participated in treatment? □ No □ Yes □ Partly	

ADULT/SOCIAL DEVELOPMENTAL HISTORY

Patient Name: _____ Date _____

HOUSING: Are you □ Renting a home/apartment □ Buying/own a home Are you living with □ Friends □ Relatives People living with you: Name/Relationship Names/Relationships _____ _____ _____ _____ Names of Children/Ages: Living with you? _____ □ No □ Yes _____ □ No □ Yes _____ □ No □ Yes _____ □ No □ Yes _____ □ No □ Yes	**Staff Use Only:**
FAMILY OF ORIGIN: ● Birth Order _____ Number of Siblings _____ Were your parents: □ Married □ Separated □ Divorced □ Unmarried If divorced, did your mother remarry or have live-in boyfriend(s)? □ No □ Yes If yes, specify _____ If divorced, did your father remarry or have live-in girlfriend(s)? □ No □ Yes If yes, specify _____ Did your family move frequently? □ No □ Yes Raised by [check the most significant person(s)]: □Biological Mother □Biological Father □Adoptive Mother □Adoptive Father □Stepmother □Stepfather □Maternal Grandmother □Maternal Grandfather □Paternal Grandmother □Paternal Grandfather □Foster Home If not raised by you biological parents, state why: _____ ● How did female caregiver punish you when you did something wrong? □Yelled □Embarrassed □Shoved □Threatened □Spanked □Lectured □Beaten □Shamed □Grounded or Restricted Privileges □Other:_____ ● How did male caregiver punish you when you did something wrong? □Yelled □Embarrassed □Showed □Threatened □Spanked □Lectured □Beaten □Shamed □Grounded or Restricted Privileges □Other:_____	
EDUCATION: Difficulty with reading/writing? □No □Yes Highest Level Completed: _____ Average grades received in high school □A □B □C □D □F Positive relationship with classmates in school? □No □Yes Positive relationship with authority figures in school? □No □Yes Any drug or alcohol use at the time? □No □Yes If yes, specify what was used, amount, and frequency of use:_____ _____ How do you learn best? □Hearing Information □Seeing □ Repetition □Experience	
WORK:	

□Employed □Unemployed □Retired □On Disability If employed, what type of work are you doing? _____ Do you enjoy your job? □No □Yes Are you currently looking for another job? □No □Yes Does household income pay for the basic necessities? □No □Yes □Barely If not working currently, what type of work was done in the past: _____	

MILITARY: Current/Previous service in the U.S. Military? □No □Yes If yes, type of discharge: _____ Anything traumatic about the experience in the service? □No □Yes If yes, please explain:	**Staff Use Only:**
MARITAL STATUS: Are: □Single □Married □Married, but separated Seperated for how long? _____ □Divorced or Annulled Divorced/Annulled for how long? _____ □Involved in a committed heterosexual relationship □Involved in a committed homosexual relationship □If single, divorced, or separated, are you in a new dating relationship? □No □Yes □If married more than one time, specify the number and length of previous marriage(s): _____ Are you happy in your current relationship? □No □Yes Are there any problems in your current relationship? □No □Yes If yes, please describe:	
STRESSORS/SUPPORT SYSTEM: Have you experienced any significant events within the past year such as death of a family member, job loss, relationship problems, etc? □No □Yes If yes, please specify: _____ Have you experienced any significant stressors such as emotional/verbal abuse, physical abuse, neglect, rape, domestic violence, etc? □No □Yes If yes, please specify: _____ List any events beyond one year ago that have had an ongoing negative impact on your life (childhood abuse, losses, divorce, etc.) _____ Who do you rely on for support? _____ What has helped you through difficult times in the past? _____ Who do you spend your free time with? □Family □Friends □Co-Workers □Self Are there any activities you used to do that you would like to do again? □No □Yes If yes, please specify:	
DEVELOPMENTAL HISTORY: Did physical maturity occur around the same age as most peers? □No □Yes Age began to date? _____ Did parents object to the individual(s) dated? □No □Yes Sexual Preference? □Male □Female □Both □Celibate □Not Sure Specify: _____ Age of first sexual experience: _____ Any legal problems growing up? □No □Yes Any running away growing up? □No □Yes Any major health problems while growing up? □No □Yes If yes, please specify: _____ Growing up were you □Very happy □Happy □Neither happy/unhappy □Unhappy	
CULTURAL/SPIRITUAL: Religious preference: _____ Importance of faith during treatment: □Not at all □Somewhat □Significant Cultural considerations: _____ Medical considerations: _____ Religious restrictions: _____	
DISCHARGE: Is there anything else you would like for us to know?	

How will you know that you have met your goals?	

ADULT GENERAL MEDICAL HISTORY

Patient's Name: _____ Date: _____

ALLERGIES/ADVERSE REACTIONS

Substance Drug/Food/Latex/Other	Reaction	Substance Drug/Food/Latex/Other	Reaction

MEDICATIONS (Prescribed/Over the Counter)

Name	Dose/Schedule	Start Date	Date of Last Dose	Reason	Effective Yes/No	Prescribed By

□No medications prescribed or regularly taken

Are there any problems with current medications? □No □Yes

If yes, please specify why? □Financial issues □Scheduling issues □Too Complex □Side Effects □Other: _____

SUBSTANCE ABUSE HISTORY (Prescribed/Street Drugs/Alcohol/Other Substances)

Drug/Substance	1st Use (approximate date or age)	Current Use (Please provide an average of use, ex. This amount per day/week/month, etc)	Last Use (Date and amount used)

GENERAL HEALTH: Current state of health: □Good □Fair □Poor Date last seen by family MD: _____ Physical Pain: □No □Yes If yes, please specify: _____ Do you receive routine dental care? □No □Yes Previous Operations/Medical Hospitalizations: Type: _____ Date: _____ Type: _____ Date: _____ Type: _____ Date: _____ Childhood Disease: □Scarlet Fever □Rebela □Polio □Mumps □Measles □Birth Defects □Rheumatic Fever	**Staff Use Only:** Height_____ Weight_____ Vital Signs_____ B/P_____ Pulse_____ Respiration_____ Temp_____
EYES/EARS/THROAT: *Have you experienced:* □Hearing Problems □Difficulty Swallowing □Chronic sore throats □Vision Problems □Sinus Problems □Other:_____ □None of These Corrective Device(s):	
HEART: *Have you experienced:* □Chest pain on exertion □High Blood Pressure □Heart Murmur □Palpitations □Low Blood Pressure □Other: _____ □None of These	
LUNG: *Do you have:* □History of Smoking □Insufficient energy for routine activities □Persistent Cough □Asthma □Breathing Problems □Chronic upper respiratory infection □Emphysema □Shortness of breath □Other: □None of these	**Staff Use Only:**
NEUROLOGICAL *Have you experienced:* □Dizziness □Tics □Seizures □Numbness □Weakness □Headaches/Migraines □Falling □Involuntary movement □Head Injury □Tremors □Stroke □Poor coordination □Other: _____ □None of these	
MUSCULOSKELETAL *Do you have:* □Difficulty walking □Fibromyalgia □Healing/Skin Problems □Back pain □Neck pain □Arthritis □Osteoporosis □Other: _____ □None of these	
GASTROINTESTINAL Current Weight: _____ Height: _____ Recent weight changes? □Lost _____lbs □Gained _____lbs Over what period of time was weight lost/gained? _____ *Have you experienced:* □Chronic constipation □Chronic diarrhea □Nausea □Vomiting Aids used to promote regularity, if any:_____ Special dietary needs, if any: _____ How many caffeinated drinks are consumed in a day? _____	Review for Dietary Consult Needs
GENITOURINARY *Do you have:* □Urinary problems □Incontinence □Urgency/frequency □Burning Are you sexually active? □No □Yes *Have you experienced:* □Unprotected sex □Infertility □Sexual performance problems Please specify: _____ **WOMEN:** □Pregnant □Planned pregnancy □Menopausal □Difficulty with menstruation, (i.e. PMS) Please specify: _____ Date of last Pap Smear: Date of last period:	

MEN: Prostate Disease? □No □Yes	

ENDOCRINE: *Do you have a history of:* □Diabetes □Hypoglycemia □Hyperthyroid □Hypothyroid □Other _____ □None of these	
EXPOSURES/INFECTIOUS DISEASES: *Have you had any exposure to:* □Pesticides □Lead Pipes □Carbon Monoxide □Lead Paint □Poison Check any of the following communicable diseases/infections that you have had exposure to in the past month: □Measles □Cold □Flu □Chicken pox □TB □Sexually Transmitted Diseases How recent was your exposure: _____ *Do you have a history of:* □Hepatitis □Tuberculosis □AIDS □Meningitis □Blood Transfusions □IV Drug Use □Sharing Needles □Sexually Transmitted Diseases □Previous reaction to TB Skin Test _____ Date of last skin test _____ If under 21 years of age, are immunizations up to date? □No □Yes □Unsure □None of these	

EXERCISE/SELF CARE ACTIVITIES:				**Staff Use Only:**
Do you: □Regularly exercise □Have a sedentary lifestyle				
Do you need help with:				
	Needs Assistance	Needs Total Care	Assistive Devices	
Walking	□	□	□Cane	
Bathing	□	□	□Wheelchair	
Hygiene	□	□	□Walker	
Feeding	□	□	□Splints	
Toileting	□	□		
Dressing	□	□		

Signature of Patient/Guardian: _____ Date: _____

Signature of Clinician: _____ Date: _____