Date:_____/_____/_____ DOB:_____

Name: _____ _____
Last First

Present Issues/illness

Sleep:_____hrs/night

Any problems: ☐difficulty falling asleep ☐waking up in middle of the night ☐nightmares ☐restless sleep

Appetite : ☐same as before ☐decreased ☐increased ☐dieting any weight changes:_____

Please check all that apply:

☐Sadness ☐Insomnia ☐Panic attacks ☐Obsessions/compulsions ☐Hopelessness
☐Guilt ☐Racing thoughts ☐Fatigue ☐Withdrawal/decrease socialization ☐Decrease interest levels
☐Irritability/easy angry ☐Aggression ☐Behavioral problems ☐Impulsivity ☐Grief/loss
☐Nightmare ☐Hyperactive ☐Depression ☐Work /School Problems ☐Appetite Changes
☐Uncontrolled fear/phobia ☐Recollection of trauma ☐Worthlessness ☐Eating disorder
☐Chronic pain ☐General overwhelming stress ☐Thoughts of hurting self ☐Paranoia ☐Anxiety
☐Active plan of hurt myself ☐Hallucinations ☐Memory impairment ☐Behavior Problems
☐Mania ☐Substance Abuse ☐Parenting Issues ☐Decrease/Increase Energy ☐Mood Swing
☐Dissociative Behaviors ☐Panic Attack ☐Marital Issues ☐Relationship Problems
☐Abuse Issues ☐Poor Concentration/Attention Problems

Social History

If patient is a child/adolescent:
Patient lives with/raised by:_____
Are parents divorced? Y/N
Any step-parents? Y/N
What grade in school? _____

If patient is an adult:
Relationship status: Single Married Divorced Widowed Life/serious partner
Any children? Y/N

Past Psychiatrist History

Have you ever seen a psychiatrist? Y/N If yes, please fill below:

Name of Physician/Clinic Duration of treatment Reason for treatment

_____ _____ _____

What diagnoses have you been treated for:

☐Major depression ☐Anxiety disorder ☐Obsessive compulsive disorder ☐Bipolar disorder
☐Schizophrenia ☐Autism ☐Eating disorder ☐Personality disorder ☐ADHD/ADD
☐Post-traumatic disorder

Other:_____

Have you been hospitalized in a psychiatric facility? Y/N If yes, please fill below:

Name of hospital Date of first hospitalization Reason for treatment

_____ _____ _____

Name of hospital Date of last hospitalization Reason for treatment

_____ _____ _____

Please circle any that apply to your psychiatric history:

History of suicidal ideation Y/N
Suicide attempt Y/N
History of aggressive/threating behavior Y/N
History of self-injury/cutting Y/N

Any history of trauma:

☐Childhood physical abuse ☐Childhood emotional/verbal abuse ☐Childhood sexual abuse
☐Childhood exposure to domestic violence ☐Combat Trauma ☐Survivor of suicide

Other: _____

Have you had a family member experience die a sudden death? Y/N

Do you now or ever had:

☐Diabetes ☐Shortness of breath while exercise ☐ Seizers while exercise
☐Palpitation while exercise ☐High blood pressure ☐Heart arrhythmia

List any medication that you are now taking. Include Non-prescription medications & vitamins or supplements:

Name of drug	**Dose (include does and number of pills/day)**
_____	_____
_____	_____
_____	_____
_____	_____

Drug allergy: _____

Substance Abuse History

Are you a smoker? Y/N If yes, how many packs do you smoke?_____

Have you smoked marijuana? Y/N If yes, how often? _____
How old were you when you started? _____

Do you consume alcohol? Y/N If yes, how often do you drink? Weekly Daily Rarely
Have you experienced alcohol withdrawal symptoms? Y/N

Have you ever attended rehab? Y/N

Family Psychiatrist History

Problem	Mother	Father	Child	Grandparent	Sister	Brother	Aunt/Uncle
Depression							
Anxiety							
Obsessive compulsive							
Anger/Aggression							
Bipolar disorder							
Schizophrenia							
Completed Suicide							
Drug Abuse							
Dementia							
Autism							