

Stepfather's Name _____ Age _____ E-Mail _____

Stepfather's Occupation _____ Work phone # _____ Cell phone # _____

Stepmother's Name _____ Age _____ E-Mail _____

Stepmother's Occupation _____ Work phone # _____ Cell phone # _____

Children (Include names, ages/marital status/occupation/grandchildren) _____

Siblings, Step-Siblings, Half-Siblings (Include names, ages/marital status/occupation/nieces or nephews) _____

Please list referral source: (PLEASE DO NOT LEAVE THIS OUT.)

_____ Referral Source _____ Phone Number of Referral Source _____

EMERGENCY CONTACT

Name _____ Relationship to you _____

Daytime Phone: _____ Cell Phone _____

Evening Phone _____

Answer the following with respect to the symptoms that bring you here today.
IF "1" IS THE WORST YOU EVER FELT AND "10" IS THE BEST, WHERE ARE YOU TODAY?

1-----2-----3-----4-----5-----6-----7-----8-----9-----10

CHIEF COMPLAINT

Describe the reason for this visit and the symptoms that you are currently experiencing.

HISTORY OF THE PRESENT ILLNESS

Describe when your current symptoms began and if they have changed over time.

Are you currently in psychotherapy? Yes _____ No _____

If yes, how long have you been in treatment with your current therapist? _____

If yes, what is the name and phone number of your therapist?

Name _____ Phone Number _____

Primary Care Physician: Name: _____

Address: _____

Phone No.: _____ Date of Most Recent Appointment: _____

List all Medications you are currently taking (including psychiatric, medical and over the counter):

DRUG	DOSE	START DATE	CONDITION BEING TREATED
•	_____	_____	_____
•	_____	_____	_____
•	_____	_____	_____
•	_____	_____	_____
•	_____	_____	_____
•	_____	_____	_____
•	_____	_____	_____
•	_____	_____	_____
•	_____	_____	_____
•	_____	_____	_____
•	_____	_____	_____

Please describe if there are/were side effects to any of the psychiatric medications (even if you are not sure if they are side effects):

What are the names and phone numbers of the physicians who are/were prescribing the medications?

Name _____ Phone Number _____

Which Medications? _____

Name _____ Phone Number _____

Which Medications? _____

Name _____ Phone Number _____

Which Medications? _____

Name _____ Phone Number _____

Which Medications? _____

Name _____ Phone Number _____

Which Medications? _____

Name _____ Phone Number _____

Which Medications? _____

PAST PSYCHIATRIC HISTORY

Describe past psychiatric history and other treatments for psychiatric symptoms and dates of treatment (include what diagnoses you were told that you had in the past and/or presently have now):

Have you ever been hospitalized for a psychiatric illness? If yes, list the hospitals and dates of admission and discharge.

FAMILY HISTORY

Is there a family history of psychiatric disorder, drug dependency and/or alcoholism? (Include parents, siblings, aunts, uncles and cousins)

PSYCHO - SOCIAL HISTORY – WORK HISTORY

Friends- Relationships – Education - Employment – Most recent Living Situation – Drug and/or Alcohol History:

DEVELOPMENTAL HISTORY

Significant events in your life since childhood other than covered in Social History:

**ANY ADDITIONAL PERSONAL HISTORY OR RELEVANT INFORMATION
You Feel Might Be Helpful:**

Are you currently having suicidal thoughts? No _____ Yes _____

If yes, do you have a plan? No _____ Yes _____

Have you ever attempted suicide? No _____ Yes _____

If yes, please explain circumstances. _____

How much coffee, tea or caffeine-containing beverages do you drink a day?

Do you smoke? Yes _____ No _____ Number of cigarettes per day: _____

Do you use recreational drugs? Yes _____ No _____ If yes, which ones and how often?

Do you drink? Yes _____ No _____ Specify number of glasses or bottles per week. _____

Please specify where beer, hard liquor or wine. _____

Do you use Motrin, Advil, Aleve, Ibuprofen or other drugs for pain or inflammations?

Yes _____ No _____ Which ones? _____.

Have you ever been treated for any of the following:

<i>YES</i>	<i>NO</i>	<i>COMMENTS (TO BE ENTERED BY PSYCHIATRIST ONLY)</i>
		Heart Disease _____
		High Blood Pressure _____
		Stroke _____
		Endocrine (including Diabetes) _____
		Arthritis or Other Bone Problems _____
		Neurological Problem/Parkinson's _____
		Cataracts/other eye problems _____
		Nose/Mouth/Throat _____
		Hearing Problems _____
		Lung/Respiratory Diseases _____
		Skin Diseases _____
		Urinary Problems _____
		Gastro-Intestinal _____
		Growths/Cancer _____
		Hospitalizations _____
		Major Operations _____
		Sexually Transmitted Diseases _____
		Kidney Disease _____
		Liver Disease _____
		Gynecologic Problems _____
		Muscular Problems _____
		Sexual Problems (inclgd., STDs) _____
		Other Medical Problems _____

Has anyone in your family had?

Blackouts _____
 Convulsions or Seizures _____
 Headaches _____
 Tremors _____
 Dizziness _____
 Forgetfulness _____
 Major Weight Loss/Gain _____

BRIEFLY DESCRIBE ANY CURRENT MEDICAL PROBLEMS _____

Has anyone in your family been treated for?

<i>YES</i>	<i>NO</i>	<i>COMMENTS (TO BE ENTERED BY PSYCHIATRIST ONLY)</i>
_____	_____	Heart Disease _____
_____	_____	High Blood Pressure _____
_____	_____	Stroke _____
_____	_____	Endocrine (including Diabetes) _____
_____	_____	Arthritis or Other Bone Problems _____
_____	_____	Neurological Problem/Parkinson's _____
_____	_____	Cataracts/other eye problems _____
_____	_____	Nose/Mouth/Throat _____
_____	_____	Hearing Problems _____
_____	_____	Lung/Respiratory Diseases _____
_____	_____	Skin Diseases _____
_____	_____	Urinary Problems _____
_____	_____	Gastro-Intestinal _____
_____	_____	Growths/Cancer _____
_____	_____	Hospitalizations _____
_____	_____	Major Operations _____
_____	_____	Sexually Transmitted Diseases _____
_____	_____	Kidney Disease _____
_____	_____	Liver Disease _____
_____	_____	Gynecologic Problems _____
_____	_____	Muscular Problems _____
_____	_____	Sexual Problems (inclgd., STDs) _____
_____	_____	Other Medical Problems _____

Have you had?

Blackouts _____
 Convulsions or Seizures _____
 Headaches _____
 Tremors _____

Dizziness _____

Forgetfulness _____

Major Weight Loss/Gain _____

Does anyone in your family have a history of:

Drug Abuse _____

Alcohol Abuse _____

Briefly describe any current medical problems. _____

Briefly describe any unusual childhood illnesses: (please give age) _____

Briefly describe any serious adult illnesses: (please give approx. age) _____

Briefly describe any hospitalizations or surgeries _____

For women of child bearing age, please record date of last menstrual period: _____