Name _____

City of Residence _____ Age _____

Marital Status: _____ Any previous marriages _____

Children: yes no *If yes, specify sex &ages* _____

Who lives in your household with you?

Name	Sex	Age	Relationship

Military Service? Yes No *If yes*, Branch?_____
Highest Rank_____ Date of service_____
Type of Discharge_____

Education, Employment and Legal History:

Highest Education Received *(please specify highest grade completed and degree)*:
_____

Are you currently employed: yes no Student

Current Occupation: _____ How Long _____

Job Difficulties?_____

If student, current grade:_____

Are you currently on disability or seeking disability? _____ if yes, please specify when and why you received disability/ or seeking disability _____

Legal Difficulties? (arrested/incarcerated/ charges/ lawsuits/ custody) Yes No
Please explain

_____

_____

Habits:

Have you ever smoked?(cigarettes/tobacco/pipes/cigar/etc) Yes No
If yes, please provide details

_____

Caffeine intake per day: Caffeinated Sodas:_____ Coffee:_____ Tea:_____

Withdrawals?_____

Alcohol use: How Much? _____ Type _____

Withdrawals/ Problems Associated_____ DWI/DUI Yes No

Drug use: (Street and/or over use of prescription drugs: example marijuana, spice, K2, xanax, sleeping pills, pain pills, crack, cocaine, stimulants, bath salts, etc)

Type_____ Problems_____

Family Medical History:
Any sudden deaths or significant family medical illnesses?

_____

_____

Medical History:
Primary Care Physician _____

Allergies to medications or adverse reactions:

_____

List All Current Diagnosis or Significant Illnesses in past and present:

_____

_____

Illness	No	Yes	Age	Still Present?	Details
Allergies/Asthma					
Birth Complications					
Seizures/ Epilepsy					
Head Injury/ Concussions					
Hepatitis/Cirrhosis Other liver problems					
HIV/AIDS					
Hypertension					
Loss of Consciousness/Vertigo					
Migraines/ Headaches					
Mitral Valve Prolapse/ Other heart problems					
Sexually transmittable Disease					
Vision Problems/Glaucoma					
Stomach Issues/ IBS/ etc					
Thyroid Problems					
Arthritis/Fibromyalgia					
Neurological problems					
Diabetes					
Vitamin Deficiency					
Other					

Have you ever had a surgical procedure: No Yes *If yes, please describe*

Type	Date	Details

Are you currently taking any medications? No Yes *If yes, please describe*

Name	Dose	Date Started	Reason

Do you take any Vitamin/ Herbal/ Over the Counter (non-prescribed) medications?

No Yes *If yes, please describe*

Name	Dose	Date Started	Reason

Symptoms list: Check symptoms that have been most bothersome or occurred frequently during **last 4 weeks.**

General Symptoms

- □ **Fever**
- □ **Repetitive, senseless thoughts**
- □ **Repetitive, senseless behaviors**
- □ **Fainting or feeling faint**
- □ **Tremors, trembling, or shakiness**
- □ **Seizures**
- □ **Easy bruising**
- □ **Skin rash**
- □ **Violent behavior**
- □ **Constant worry**
- □ **Irritability**
- □ **Tension**
- □ **Headache**
- □ **Feeling in a dreamlike state**
- □ **Fearful feelings**
- □ **Fear of losing control**
- □ **Jumpiness**
- □ **Restlessness**
- □ **Sweating**
- □ **Dizziness/lightheadedness**
- □ **Keyed up/on edge**
- □ **Agitation**
- □ **Nervousness**
- □ **Trouble concentrating**
- □ **Insomnia/trouble sleeping**
- □ **Decrease in sex drive**
- □ **Trouble making decisions**
- □ **Sad/depressed/down in the dumps**
- □ **Lack of/loss of interest in things**
- □ **Helpless feelings**
- □ **Fatigue/lack of energy**
- □ **Weakness**
- □ **Increase or decrease in appetite**
- □ **Increase or decrease in weight**
- □ **Frequent crying or weeping**
- □ **Worthless feelings**
- □ **Excessive feelings of guilt**
- □ **Hopeless feelings**
- □ **Feeling life is not worth living**
- □ **Sleeping too much**
- □ **Frequent negative feelings**
- □ **Memory problems**
- □ **Free of doing something uncontrollable**
- □ **Fear of dying**
- □ **Chills**
- □ **Seeing or hearing things**
- □ **Fear of going crazy**

EYES & EARS

- □ **Double Vision**
- □ **Difficulty in focusing vision**
- □ **Eye pain**
- □ **Sinus pain**
- □ **Increase or decrease in tearing**

Cardiovascular

- □ **Chest pain**
- □ **Chest discomfort**
- □ **Heart pounding**

Gastrointestinal

- □ **Diarrhea**
- □ **Constipation**
- □ **Heartburn**
- □ **Rectal bleeding**
- □ **Black, tarry stool**
- □ **Stomach pain**
- □ **Food intolerance**
- □ **Abdominal bloating**

Respiratory/Nose/Throat/Mouth

- □ **Cold (influenza)**
- □ **Nasal congestion**
- □ **Nosebleeds**
- □ **Hay fever**
- □ **Cough**
- □ **Wheezing**
- □ **Shortness of breath**
- □ **Pain when breathing**

URINARY

- □ **Frequent urination**
- □ **Painful urination**
- □ **Difficulty passing urine**
- □ **Blood in urine**

Other Symptoms not Listed Above

_____
_____
_____
_____

Neuropsychiatric History:

Age of first psychiatric symptoms: _____ Age of First Treatment _____

What were the first symptoms? _____

_____

_____

Have you ever had motor or vocal tics? No Yes if yes, details _____

Have you ever sought professional treatment for any psychiatric, substance abuse, or any problems listed above? No Yes *if yes, please describe below*

See scales below in describing the details					
Problem (Diagnosis)	Start Date	Stop Date	Type of Treatment	Setting	Outcome

<u>Type of treatment</u>: 1= Medication Therapy 2= Talk Therapy 3= Other

<u>Setting:</u> Inpatient-Hospital / Outpatient / Day Program/ Rehab

Treatment with ECT/ Biofeedback/ Hypnosis? No Yes *if yes please describe*

_____

_____

Family History:

Are you Adopted? Yes No
Do you have siblings? _____ If yes, how many _____

Do you have any blood relatives who have a serious emotional, behavioral, neurological, or substance abuse problem? Yes No

If yes, please complete

Name	Age	Relationship	Problem/ Medication

How would you describe your childhood family life? Stable Unstable

Did you experience any of the following during your childhood or adolescence?

Check and complete all that apply

Yes	Situation	Your Age	Duration	Comments
	Death of parent		n/a	
	Death of loved one		n/a	
	Separation from parent or family			
	Parents' divorce/ separation		n/a	
	Loss of home			
	Family financial problems			
	Physical abuse			
	Sexual abuse			
	Rape			
	Parent with substance abuse problem			
	Conflicts with parents			
	Foster care			
	Unwanted child			
	School problems			
	Illness in self			
	Illness in family			
	Problems with walking/talking on time as a child (developmental delays)			
	Other			

Medication History:

Have you ever been treated for emotional or psychiatric problems with medication?

Yes No

Medications (trade name)	No	Yes	Start Date	Stop Date	Dose (max)	Symptom Treated	Response Good, fair, poor	Side Effects?
Antidepressants								
Paroxetine (paxil,pexeva)								
Sertaline (zoloft)								
Fluoxetine (prozac, sarafem)								
Citalopram (celexa)								
Escitalopram (lexapro)								
Venlafaxine (effexor, XR)								
Desvenlafaxine (pristiq)								
Duloxetine (cymbalta)								
Vilazodone (vibryd)								
Levomilnacipran (fetzima)								
Vortioxetine (brintellix)								
Buproprion (wellbutrin, SR, XL)								
Mitrazapine (remeron)								
Trazodone ER (oleptro)								
Trazadone (desyrel)								
Fluvoxamine (luvox, CR)								
Amitriptyline (elavil)								
Selegeline (emsam)								
Other (Nardil, parnate MAOI's, Nortriptyline, Pamelor)								

Medication History, cont.:

Medications (trade name)	No	Yes	Start Date	Stop Date	Dose (max)	Symptom Treated	Response Good, fair, poor	Side Effects?
Antipsychotics/Mood Stabilizers								
Ziprasidone (geodon)								
Aripripazole (abilify)								
Risperidone (risperdal)								
Palperidone (invega)								
Quetiapine (seroquel, xr)								
Olanzapine (zyprexa)								
Asenapine (saphris)								
Lurasidone (latuda)								
Olanzapine/ fluoxetine (symbyax)								
Clozapine (clozaril)								
Haloperidol (haldol)								
Other (fanapt, navane, etc)								
Lithium (eskalith, lithobid)								
Valproic Acid (depakote, ER)								
Carbamazepine (tegretol)								
Oxcarbazepine (trileptal)								
Lamotrigine (lamictal)								
Topiramate (topamax)								
Other								

Medication History, cont:

Medications (trade name)	No	Yes	Start Date	Stop Date	Dose (max)	Symptom Treated	Response Good, fair, poor	Side Effects?
Anti-Anxiety/ Sleep Aids								
Clonazepam (klonopin)								
Diazepam (valium)								
Lorazepam (ativan)								
Alprazolam (xanax, XR)								
Buspar (buspirone)								
Chlorazepate (tranxene)								
Temazepam (restoril)								
Chlordiazepoxide (librium)								
Oxazepam (serax)								
Chloral hydrate (noctec)								
Hydroxyzine (atarax, vistaril)								
Zaleplon (sonata)								
Zolpidem (ambien, CR)								
Trazodone (desyrel)								
Eszopiclone (lunesta)								
Ramelteon (rozerem)								
Other (doxepin, nortriptyline)								

Medication History, cont. :

Medications	No	Yes	Start Date	Stop Date	Dose (max)	Symptom Treated	Response Good, fair, poor	Side Effects?

Stimulants (ADHD)/ Narcolepsy/ Appetite Suppressants

Ritalin, LA, SR								
Methylin ER								
Concerta								
Metadate, ER, CD								
Adderall, XR								
Daytrana (patch)								
Vyvanse								
Focalin (denote if XR)								
Strattera								
Provigil,Nuvigil								
Intuniv								
Kapvay								
Dexedrine								
Tenuate								
Phentermine								
Meridia								
Other								

Medication History, cont. :

Medications	No	Yes	Start Date	Stop Date	Dose (max)	Symptom Treated	Response Good, fair, poor	Side Effects?

Alcohol/Drug/Smoking Cessation

Chantix								
Campral								
ReVia (naltrexone)								
Suboxone								
Methadone								
Antabuse								
Other								

Miscellaneous

Benadryl								
Benztropine (cogentin)								
Amantadine (symmetrel)								
Clonidine (catapres)								
Thyroid (cytomel, synthroid)								
Propanolol (inderal)								
Cyproheptadine (Periactin)								
Other								