Health Information and Symptom/Problem Survey

Patient: _____Provider: _____Date : _____

Person completing this form: _____

Main reasons and problems for which you are now seeking services? _____
_____

Please list diagnoses that you were previously given and the treatment that you received: _____
_____

Primary Care Physician (PCP) name: _____
PCP Address: _____
City: _____State: _____Zip Code: _____
Phone Number: _____Fax Number: _____Email: _____

Who referred you to us? _____

Do we have your permission to communicate with your primary care physician? __yes ___no

Name of your Pharmacy: _____Phone: _____

1. Please indicate below the medical conditions that you have had:

❒ None
❒ Arthritis
❒ Bronchial Asthma
❒ Cerebrovascular Accident
❒ Coronary Artery Disease
❒ Diabetes
❒ Acid Reflux or other stomach problems
❒ Head Trauma
❒ Hepatic Disease
❒ HIV/AIDS
❒ Hypertension
❒ Heart Condition or Heart Attack
❒ Migraines
❒ Kidney Disease
❒ Seizures
❒ Chronic Pain/Injuries
❒ Crones Disease
❒ Multiple Sclerosis
❒ Other: _____
❒ Note: _____

2. Past Surgeries Relevant to the Current Services that you are seeking?
❒ None
❒ Details of relevant surgeries: _____
_____

3. Mark below, the behavioral health conditions that your close biological family members have been diagnosed or have been suspected of having?
❒ ADHD
❒ Addictions
❒ Alzheimer's
❒ Anxiety
❒ Bipolar
❒ Depression
❒ Eating Disorders
❒ OCD
❒ Positive in biological relatives
❒ Schizophrenia
❒ Other: _____

4. What medications and dosages are you currently taking for behavioral health reasons (i.e. anxiety; depression; bipolar disorder): _____
_____

5. What medications and dosages are you taking for physical health reasons?_____
_____

6. Which medications have you or your family members taken for similar conditions for which you are seeking services and have they been effective? _____
_____

7. Are you allergic to any medications, substances or foods? Which?_____
_____

8. Do you use tobacco or alcohol or drugs that are not prescribed? What and how often? _____
_____

9. Marital Status:

❒ Married
❒ Single
❒ Divorced
❒ Widowed
❒ Separated
❒ Domestic Partner

10. Children:

❒ The Patient is a child
❒ Names/Ages: _____
❒ None

11. Developmental Symptoms:

❒ None
❒ Tics
❒ Mental Retardation
❒ Note: _____
❒ Participated in special programs at school
❒ Learning Disorder
❒ Developmental Disorder

12. Developmental History: Did you have problems in health or development during birth, infancy, childhood?

❒ Normal, Unremarkable
❒ Not Relevant
❒ Note: _____
❒ Relevant

13. Please indicate your current Social Support:

❒ Family/Friends local
❒ Family out of area are/ involved
❒ Note: _____
❒ Minimal Family/Friends contact

14. Please note a little about your family, employment, education, religion, etc. or life events (deaths, births, divorce, job loss, etc.) which you have experienced that you believe are important for your provider to know: _____
_____

15. Please list what you believe are your Strengths/Abilities:

❒ Average or above intelligence
❒ Supportive family and/or friends
❒ Motivation for treatment/ growth
❒ Capable of independent living
❒ Work skills
❒ Religious affiliation
❒ Active sense of humor
❒ Ability for insight
❒ Communication skills
❒ Financial means
❒ Special hobby/interest

16. Please list your Weaknesses/Challenges which may hinder your progress:

❒ Loss (deaths; break-ups; other)
❒ Legal issues
❒ Marital or family conflict
❒ Financial difficulties
❒ Traumatic event
❒ Educational concerns
❒ Substance abuse
❒ Medication change or non-compliance
❒ Occupational concerns
❒ Health problems

Survey of Mental Illness Symptoms Related to Diagnostic Categories.
Please Mark your current symptoms with a checkmark.

17. Depression Symptoms:

- ❒ None
- ❒ Depressed Mood
- ❒ Appetite Disturbance
- ❒ Insomnia (can't sleep)
- ❒ Hypersomnia (sleeps too much)
- ❒ Fatigue
- ❒ Decreased Concentration
- ❒ Loss of Interest in Usual Activities
- ❒ Significant Weight Loss or Gain
- ❒ Restlessness/ Psychomotor
- ❒ Agitation
- ❒ Sluggishness
- ❒ Feelings of Worthlessness or Guilt
- ❒ Thoughts of Death or Suicidal Ideation (*Complete Risk Assessment*)
- ❒ Irritability

❒ Note: _____

21. Suicide Risk Assessment:

- ❒ None
- ❒ I have attempted suicide in the past
- ❒ I do not have suicidal thoughts
- ❒ I have suicidal thoughts, but would not act on them and have no plan.
- ❒ I have suicidal thoughts and think about ways I would kill myself, I often have intent
- ❒ I agree to contact a Crisis Line, relatives or 911, if my suicidal intent activates.
- ❒ Note: _____

22. Mania Symptoms:

- ❒ None
- ❒ Elevated, expansive, or irritable mood
- ❒ Talkative or pressure to keep talking
- ❒ Distractibility
- ❒ Can't stop an activity or my agitation
- ❒ Can't stop thinking about grand plans
- ❒ Racing thoughts
- ❒ Excessive involvement-pleasurable activities
- ❒ Become unaware of my behavior and circumstances

23. OCD/Anxiety Symptoms:

- ❒ None
- ❒ Think about the same things again and again/ ruminations
- ❒ Repetitive behaviors
- ❒ Rapid heartbeat, sweats, shakes, or chest pains
- ❒ Shortness of breath, nausea, dizziness, derealization
- ❒ Fear of dying or losing control, depersonalization
- ❒ Anxiety about being in a place where exiting is difficult
- ❒ Avoidance of such places
- ❒ Fear of animals, nature, blood, injections

24. Trauma/PTSD Symptoms:

- ❒ None
- ❒ Avoids events that remind of trauma, unable to recall event, detachment
- ❒ Deja-vu
- ❒ Distressing recollections or dreams
- ❒ Distress/fear related to an event
- ❒ Repeated thoughts about traumatic event
- ❒ Trouble with sleep, irritable, hypervigilance
- ❒ Experienced traumatic event(s)
- ❒ Repeat exposure to traumatic events, learned about trauma with loved ones
- ❒ Re-exposure trauma or intrusion symptoms: dreams, nightmares, flashbacks
- ❒ Avoidance: Efforts to avoid thoughts, feelings or events
- ❒ Hyperarousal: Aggressive behavior, irritability, reckless behavior
- ❒ Negative distortions in cognitions, thoughts, moods, or feelings
- ❒ Dissociative symptoms: Amnesia/memory gaps, derealization, depersonalization

25. Schizo-Affective Symptoms:

- ❒ None
- ❒ See things that others don't
- ❒ Hear things that others don't
- ❒ Delusions
- ❒ Grandiose Ideas that others think impossible
- ❒ Persecutory: Feel like people or agencies are out to do me wrong
- ❒ Disorganized speech
- ❒ Isolated, no friends.
- ❒ Loss of ability to speak/ mutism
- ❒ With postpartum onset

❒ Note: _____

26. Cognition Symptoms:

- ❒ None
- ❒ Impaired Thinking and Planning
- ❒ Disturbance of sight or balance or perception
- ❒ Disturbance fluctuates or develops over short period of time
- ❒ Memory Impairment
- ❒ Aphasia: Can't comprehend or find words or phrases to speak
- ❒ Can't coordinate my physical body movements
- ❒ Disturbance in ability to plan and organize

❒ Note: _____

27. Substance Abuse Symptoms and/or Concerns:

- ❒ None
- ❒ Substance abuse or alcohol abuse/addictions are a concern
- ❒ Note: _____

28. ADHD Symptoms:

- ❒ None
- ❒ Planning problems
- ❒ Hyperactivity
- ❒ Poor concentration
- ❒ Follow through problems
- ❒ Distractibility

❒ Eating Disorder Symptoms: _____

❒ Conduct/Behavior Symptoms: _____

29. Please write about what you believe to be important regarding your symptoms: _____