Patient Health Information

Patient: _____ DOB:_____ Provider: _____ Date of Service: _____

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
    - ❒ None
    - ❒ Names/Ages: _____

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

12. Developmental History: Did you have problems in health or development during birth, infancy, childhood?
    - ❒ Normal, Unremarkable
    - ❒ Not Relevant
    - ❒ Relevant
    - ❒ Note: _____

13. Please indicate your current Social Support:
    - ❒ Family/Friends local
    - ❒ Family out of area are/involved
    - ❒ Minimal Family/Friends contact
    - ❒ Note: _____

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: _____

18. 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: _____

19. 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

20. Anxiety Symptoms:

- ❒ None
- ❒ Worry about the same things again and again/ruminations
- ❒ 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

21. Obsessive Compulsive Symptoms:

- ❒ None
- ❒ Recurrent and persistent thoughts; urges
- ❒ Major effort to suppress thoughts and urges
- ❒ Repetitive behaviors: handwashing, counting, etc.
- ❒ Above patterns engaged in to reduce distress

22. Conduct Disorder Symptoms:

- ❒ None
- ❒ Aggression to people or animals
- ❒ Deceitfulness; Theft
- ❒ Destruction of property in fine setting
- ❒ Serious Violations of rules (Truant, Running)

23. 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

24. 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: _____

25. 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: _____

26. Substance Abuse Symptoms and/or Concerns:

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

27. ADHD Symptoms:

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

❒ Eating Disorder Symptoms: _____

❒ Conduct/Behavior Symptoms: _____

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

_____

_____

29. If you would like to release information about your care to another agency, professional or person please complete a specific RELEASE OF INFORMATION FORM. Request this form.

Signature of Responsible Party: _____**Date:** _____