Client Name: _____ Date of Birth: / / Client #: _____ Date: _____

Version 3, November 2012

Past Psychiatric Information

Prior Out-patient Psychiatrists/ Medication treatment ***including:*** dates, names of medications & reason treated:

Name of current Psychiatrist and names, dosage, & notable side effects of current medication:

Prior Out-patient Therapy (individual & group) including names, dates & reason treated:

Prior In-patient, PRP (psychiatric rehabilitation program) or Partial psychiatric hospitalization, IOP and group homes ***including:*** dates, names of medications & reason treated:

When did the above psychiatric concerns first start?

What symptoms and behaviors did you experience as part of the above psychiatric concerns?

Has anyone in your family ever been diagnosed with or thought to have symptoms of any mental disorder? If so, whom and what illness? Any suicide attempts by family members?

Current Psychiatric Information (PLEASE COMPLETE ON BACK SIDE OF SHEET)

What are you coming to see me for? (What is your presenting concern?)

Why are you coming now? (What are the circumstances leading to us talking?)

When did your current concern start?

Please continue psychiatric information on the back of the page as needed

Medical History

Please circle if you have: Asthma/COPD | Cancer | Cardiovascular Disease | Chronic Pain | Dementia | Diabetes | Obesity

Please list any other past and present major medical conditions:

Please list all current medications you are taking for medical conditions:

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Please list past and present medical conditions that you believe have had an impact on your mental health:

Are you currently experiencing pain? How severe on a scale from 1 to 10?
What is the name of your PCP?
Please list any routine exercise done and typical eating habits.

Psychosocial History

Marital Status (circle one): married, domestic-partner, divorced, separated, single
Children's names & ages (if any):_____
Other family/ household members:

Please list people who are emotionally supportive of you:_____

Do you have a history of interaction with the law? If so, what:_____

What was your birth like? Any developmental issues (did you learn to walk and talk, etc at typical ages)?

Please list any childhood issues of trauma or loss? Were you ever abused either physically, emotionally or sexually as a child or adolescent?

What is your current living situation and is it safe?
Highest degree you have achieved (circle one): high-school, 2-yr-college, 4-yr-college, masters, doctorate, other

What was your experience like in school? Achievements? Struggles? Supports?

What are your hobbies, interests, & daily activities?:_____

What are your strengths, supports and resources?

Name & age of parents (if deceased, cause & age at death):_____
Nature of relationship with parents (past & current):_____

Sibling's names & ages (if any):_____

Work History

Please list last four job titles & dates held:

What are your career goals?
How satisfied are you with current job (if employed)?

Have you ever served in the military? If so, when and what type of discharge did you receive?

Medication/Drug History

List frequency and quantity of caffeinated beverages, nicotine products, alcohol, illegal drugs, and marijuana taking

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currently and in the past:

Have you ever been hospitalized for **substance abuse** concerns? If so -- please list facility information, reason, and dates as best you can remember. Please list number of hospitalizations in past 12 months and in your life-time.

Please continue substance abuse information on the back of the page as needed.

Alcohol & Drug Use:

When thinking about drug use, include illegal drug use and the use of perscription drug use other than prescribed. Please circle YES or
NO for each question.

1. Have you ever felt that you ought to cut down on your drinking or drug use? | YES / NO
2. Have people annoyed you by critizing your drinking or drug use? | YES / NO
3. Have you ever felt bad or guilty about your drinking or drug use? | YES / NO
4. Have you ever had a drink or used drugs first thing in the morning to steady your | YES / NO
nerves or get rid of a hangover?

Special Factors

Are you currently suicidal or homicidal?_____

Do you have a history of either one?_____

Are you court-ordered or otherwise required to receive treatment?_____
Do you have a history of self-mutilation such as cutting or burning yourself?_____
Have you ever been diagnosed with, or thought to have, anorexia or bulimia?_____
Do you have weapons in your home?_____
Have you ever set fires or mistreated animals?

As an adult, have you ever suffered from abuse (physical, sexual or emotional), or other significant trauma or loss? Please list ages and in very general, non-specific way the type of trauma.

Have you every experienced hallucinations or delusions?

Have you had any recent changes in appetite, sleep patterns or ability to focus?
How is your memory?

Goals for Treatment: (PLEASE COMPLETE ON BACK SIDE OF SHEET)

Short-term goals:

Long-term goals:

Client signature and date for goals: _____