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PATIENT HISTORY INTAKE FORM

Name: _____ Date: _____

Birthdate: _____ Age:_____

MARITAL & FAMILY HISTORY:

Are you currently married?_____How long?_____

How many times have you been married?_____

Are you now separated or divorced? _____Since when? _____

How many children do you have?_____

MEDICAL HISTORY:

What current medical and/or mental health problems do you have?

a. _____ d. _____

b. _____ e. _____

c. _____ f. _____

What are the names of the doctors who are presently treating you?

What medications are you taking?

Have you ever been seen by a psychiatrist, psychologist, or any other mental health professional?_____
If so, please give their *names*, approximate *dates* seen,and the *reasons* for seeing them:

NAMES DATES REASONS FOR BEING SEEN

Please describe any psychiatric inpatient treatment or hospitalizations:

HOSPITALS DATES REASONS FOR TREATMENT

EMPLOYMENT AND EDUCATION:

Last grade of school completed_____ Highest diploma or degree earned:_____

What is your current employment?_____

If you are not presently employed, when did you last work?_____

Have you ever been in the military service?_____ Which Branch?_____

PLEASE CHECK ANY OF THE FOLLOWING SYMPTOMS WHICH DESCRIBE YOU NOW:

- ❒ Losing track of time
- ❒ Getting lost and disoriented
- ❒ Forgetfulness
- ❒ Other memory problems
- ❒ Confused, mixed-up thinking
- ❒ Changes in my intellectual abilities

- ❒ Changes in my personality
- ❒ Disturbances in my mood
- ❒ Problems in controlling my emotions
- ❒ Problems in controlling my impulses
- ❒ Emotional withdrawal and isolation
- ❒ Significant dependence on others
- ❒ Unstable interpersonal relationships
- ❒ Problems living independently and caring for myself
- ❒ Self-destructive behavior
- ❒ Committing a crime or breaking the law _____
- ❒ Significant loss of interest in my activities
- ❒ Change in appetite and/or weight
- ❒ Problems falling asleep and/or staying asleep
- ❒ Restless and agitation
- ❒ Decreased energy
- ❒ Feelings of guilt or worthlessness
- ❒ Difficulty concentrating or thinking
- ❒ Not being able to enjoy what I'm doing nor being able to take pleasure in activities which I usually enjoy
- ❒ Thoughts of suicide

- ❒ Hyperactivity
- ❒ Talking too fast or rapid, forced or pressured speech
- ❒ Racing ideas and thoughts, with my mind going "a mile a minute"
- ❒ Overinflated view of my skills, abilities, and self-worth
- ❒ Decreased need for sleep
- ❒ Easily distractible
- ❒ Risky, careless, and costly behavior
- ❒ Significant mood swings

- ❒ Apprehension
- ❒ Excessive vigilance, worrying that something bad may be about to happen
- ❒ Specific fears
- ❒ Panic attacks
- ❒ Recurrent thoughts which I can't control
- ❒ Repetitive actions which I can't control
- ❒ Remembering traumatic experiences
- ❒ Nightmares of traumatic experiences

- ❒ Unusual or strange thinking
- ❒ Delusions (False Beliefs)
- ❒ Hallucinations (Perceiving things that are not there)
- ❒ Suspicious or paranoid thinking
- ❒ Peculiar thoughts, perceptions, speech, or strange behavior

❒ **Alcohol Use** (present) _____(past if different)_____

❒ **Drug Use (not prescription)** (present) _____(past if different) _____

- ❒ Vision
- ❒ Speech
- ❒ Hearing
- ❒ Muscle tension
- ❒ Use of my arms or legs
- ❒ Problems controlling my body's movement (e.g. coordination, problems, seizures, etc.)
- ❒ Changes in sensation
- ❒ Concerns about having a serious disease or injury, although medical examinations have not confirmed the presence of such illness
- ❒ Feelings of being physically upset
- ❒ Chronic Pain

Please List Any Other Issues You Would Like To Discuss With The Doctor:

_____

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