

Psychiatric History

Place a check to indicate if any problems apply currently (in the last six months) or in the past.

Now	Past		Now	Past	
___	___	Suicidal thoughts	___	___	Homicidal thoughts
___	___	Depression/sadness	___	___	Anxiety/nervousness
___	___	Recurrent/intrusive thoughts	___	___	Nightmares
___	___	Difficulty sleeping	___	___	Loss of appetite
___	___	Overeating	___	___	Weight loss
___	___	Weight gain	___	___	Sexual problems
___	___	Visual/auditory hallucinations	___	___	Apathy
___	___	Anorexia/Bulimia	___	___	Explosive anger
___	___	Rapid mood changes	___	___	Euphoria (feel on top of the world)
___	___	Decreased need for sleep	___	___	Racing thoughts
___	___	Distractible	___	___	Feeling worthless
___	___	Fatigue	___	___	Loss of interest in almost all activities
___	___	Poor self esteem	___	___	Feelings of hopelessness
___	___	Overwhelming need to perform certain behaviors/rituals	___	___	Recurrent/intrusive disturbing recollections or dreams
___	___	Significant concerns with physical problems	___	___	Excessive fears or phobias
___	___	Other problems: _____			

Indicate which stressors you are experiencing currently (within the last 6 months) or in the past.

Now	Past		Now	Past		Now	Past	
___	___	Death of spouse	___	___	Death of family member	___	___	Illness of family member
___	___	Illness of friend	___	___	Personal injury/illness	___	___	Marital difficulties
___	___	Marital separation	___	___	Divorce	___	___	Sexual difficulties
___	___	Conflicts with family	___	___	Conflicts with friends	___	___	Conflicts at work
___	___	New job	___	___	Job termination	___	___	Retirement
___	___	Business difficulties	___	___	Academic difficulties	___	___	Financial problems
___	___	Change in residence	___	___	Legal problems	___	___	Sexual assault
___	___	Incest/sexual abuse	___	___	Physical abuse	___	___	Verbal/emotional abuse
___	___	Other problems: _____						

Are you currently receiving therapy? _____ From who? _____
 When did you start therapy? _____ For what problem(s)? _____

List current psychiatric medications: _____

Have you received therapy in the past? _____ From who? _____
 When (Start and finish): _____ For what problem(s)? _____

List past psychiatric medications: _____

Have you been hospitalized for psychological problems? _____ When? _____
 Where were you hospitalized? _____
 Have you ever attempted suicide? _____ When? _____ How? _____

Medical History

Please check all the conditions that have been diagnosed as a child or an adult.

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> AIDS, ARC or HIV+ | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Immune system disease | <input type="checkbox"/> Poisoning |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Enzyme deficiency | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Encephalitis | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Liver disorder | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Abscessed ears | <input type="checkbox"/> Fevers (104 or higher) | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Radiation exposure/therapy |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Genetic disorder | <input type="checkbox"/> Lead poisoning | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Head injury or concussion | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Senility (Dementia) |
| <input type="checkbox"/> Blood disorder | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Metabolic disorder | <input type="checkbox"/> Stroke or TIA |
| <input type="checkbox"/> Broken bones | <input type="checkbox"/> Hereditary disorder | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Brain disease/infection | <input type="checkbox"/> Hazardous substance exposure | <input type="checkbox"/> Measles | <input type="checkbox"/> Tumor |
| <input type="checkbox"/> Cerebral palsy | <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Mumps | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Colds (excessive) | <input type="checkbox"/> Huntington's disease | <input type="checkbox"/> Malnutrition | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Vision problems |
| <input type="checkbox"/> Carbon monoxide poisoning | <input type="checkbox"/> Hormone problems | <input type="checkbox"/> Oxygen deprivation | <input type="checkbox"/> Whooping cough |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hazardous substance exposure | <input type="checkbox"/> Pneumonia | |
| <input type="checkbox"/> Other medical problems _____ | | | |

Have you ever been diagnosed with epilepsy or a seizure disorder Yes ___ No ___ If yes, check the one you have been diagnosed with.

PARTIAL

- Simple partial (Jacksonian)
- Complex partial (Psychomotor)
- Partial evolving into generalized

GENERALIZED

- Absence (Petit mal)
- Myoclonic
- Clonic
- Tonic
- Tonic-clonic (Grand mal)
- Atonic

___ UNCLASSIFIED TYPE

List any medications currently being taken (over-the-counter or prescription), and the dosage.

Medication and Dosage

- | | |
|----------|----------|
| 1) _____ | 4) _____ |
| 2) _____ | 5) _____ |
| 3) _____ | 6) _____ |

List any medications you are ALLERGIC or sensitive to: _____

Past Hospitalizations (When, where and for what):

Outpatient Surgeries (When, where and for what):

Circle substances you currently use (Even if only occasionally or in small amounts):

Alcohol	Tobacco	Marijuana	Barbiturates ("Downers")	Tranquilizers
Amphetamines ("Speed")	Crank	Crack	Cocaine	Opiates (Heroin, Opium, Codeine, etc.)
Hallucinogenics (LSD, STP, "Magic Mushrooms", etc.)			PCP ("angel dust")	Other: _____

Circle substances you have taken in the past (Even if only occasionally or in small amounts):

Alcohol	Tobacco	Marijuana	Barbiturates ("Downers")	Tranquilizers
Amphetamines ("Speed")	Crank	Crack	Cocaine	Opiates (Heroin, Opium, Codeine, etc.)
Hallucinogenics (LSD, STP, "Magic Mushrooms", etc.)			PCP ("angel dust")	Other: _____

Have you had a prior psychological or neuropsychological evaluation? Yes ___ No ___ If yes, complete this information:

Name of psychologist: _____
 Address: _____
 Phone: _____ Date of and reason for this evaluation: _____
 Findings of the evaluation: _____

Family History

Father's Name _____ Age _____ Health Problems _____
 Education _____ Occupation _____ Employer _____
 Mother's Name _____ Age _____ Health Problems _____
 Education _____ Occupation _____ Employer _____
 Date of parent's marriage _____ Years married _____ Current marital problems? _____ If separated, give date _____
 If divorced, date _____ Previous marriages? (Father) _____ (Mother) _____ Subsequent marriages? (Father) _____ (Mother) _____
 If divorced, current custody arrangement _____

Please provide information regarding step-parents if your parents are divorced:

Name	Age	Education	Occupation	Date Married	! Years
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Names and ages of siblings (Include step-brothers and step-sisters):

List anyone else who lived in the home during your childhood: _____

List names of any family members (E.G. Immediate and distant relatives) with any of the following problems:

Alcohol/drug abuse _____
 Criminal history _____
 Emotional/behavioral problems _____
 Medical problems (e.g. Heart disease, Cancer, Seizures) _____
 Learning/developmental problems _____

Birth and Developmental History

Place of Birth: _____ Were parents married at time of birth? _____
Was mother under a doctors care during the pregnancy? _____ adopted? _____ If so, at what age? _____

Were drugs or alcohol taken during pregnancy? Yes ___ No ___ If yes, specify: _____

Circle any problems that occurred in later development:

Hearing	Speaking	Stuttering	Reading	Writing	Spelling	Arithmetic
Behavior	Hyperactivity	Attentional difficulties		Seizures	Coordination	

List family members with developmental or learning problems: _____

Educational History

Current grade (Or highest grade/degree completed): _____ Current school: _____
Past schools attended (list in order): _____

Hardest subject(s): _____ Favorite subject(s): _____
Grades earned in elementary school: _____ Junior High G.P.A. _____ High School G.P.A. _____ College G.P.A. _____
Grades repeated: _____ Learning problems (what subjects): _____
Special education placement (Type): _____ During which grades: _____
Extracurricular activities (Music, Sports, Clubs, etc.): _____
Expulsions/suspensions/conduct problems (Type of problem and date): _____
Additional schooling or non-academic training: _____

Social History

If single or separated, are you currently dating anyone? _____ How long? _____ Is it a serious relationship? _____
First name: _____ Are you currently sexually active? _____ If not dating, when was your last date? _____
How long did you date that person? _____ Was it a serious relationship? _____ First name: _____

Please list "significant others" you have lived with but not married.

Current/Most Recent Cohabitation

Date began: _____ Number of years together: _____ Date ended: _____
Name: _____ Age: _____ Health: _____
Education: _____ Occupation: _____
Type of relationship problems: _____
Names and ages of children: _____
If separated, what is the custody arrangement: _____

Prior Cohabitation

Date began: _____ Number of years together: _____ Date ended: _____
Name: _____ Age: _____ Health: _____
Education: _____ Occupation: _____
Type of relationship problems: _____
Names and ages of children: _____
If there are children, what is the custody arrangement: _____

Have you lived with anyone else in the past? Yes No How many times? _____
Any other children outside of marriage? Yes No Names/Ages: _____
Any aborted pregnancies/miscarriages? Yes No When? _____

List clubs and organizations you are involved with and how often you attend: _____

Do you attend church? (where and how often): _____

What do you do with your free time: _____

When was your last vacation (Please describe): _____

How many close friends do you have in the community: _____ How often do you get together with friends or family: _____

How long have you lived in the community: _____ Where have you lived in the past: _____

DOCTORS NOTES

Marital History

Marital Status: Single Married Separated Divorced Widowed

Current Marriage

Date of marriage: _____ Number of years married: _____ Date of separation: _____ Date of divorce: _____
Spouse's name: _____ Age: _____ Health: _____
Education: _____ Occupation: _____
Type of marital problems: _____
Names and ages of children: _____
If divorced/separated, what is the custody arrangement: _____

Prior Marriage

Date of marriage: _____ Number of years married: _____ Date of separation: _____ Date of divorce: _____
Spouses name: _____ Age: _____ Health: _____
Education: _____ Occupation: _____
Types of marital problems: _____
Names and ages of children: _____
If divorced/separated, what is the custody arrangement: _____

Prior Marriage

Date of marriage: _____ Number of years married: _____ Date of separation: _____ Date of divorce: _____
Spouses name: _____ Age: _____ Health: _____
Education: _____ Occupation: _____
Types of marital problems: _____
Names and ages of children: _____
If divorced/separated, what is the custody arrangement: _____

List any other marriages and children: _____

List names of spouses or children with the following problems:

Developmental/Learning problems: _____
Emotional/Behavioral problems: _____
Alcohol/Drug abuse: _____
Medical problems: _____

DOCTORS NOTES

Occupational History

Present employer: _____ Position: _____
Length of employment: _____ Hours worked per week _____ Current responsibilities: _____

List previous employment for last ten years (Include dates and type of work):

Have you ever been terminated from a job (Please explain): _____

At any time on the job were you ever exposed to dangerous chemicals or substances (e.g., Mercury, Lead, Radiation, Solvents, Pesticides, Chemicals, etc.)? Yes ___ No ___ If yes, explain: _____
Have you ever been injured on the job? Yes ___ No ___ If yes, explain: _____

Military Service

Branch of service: _____ Dates of service: _____
Job(s) within service: _____
Highest rank: _____ Rank at discharge: _____ Discharge status: _____
Were you exposed to any dangerous or unusual substances (e.g. Agent Orange, Radiation, etc.) Yes ___ No ___
If yes, explain: _____
Did you sustain any physical injuries in the military? Yes ___ No ___ If yes, explain: _____

Legal History

Present legal problems (Describe): _____
Past arrests (For what?): _____
Convictions (For what?): _____
Time served in juvenile hall, jail or prison (Give dates and locations): _____
