

Patient Name

Medical Records Chart #

Adult Self Report Form

DOB: _____

The following questions will help us in serving you. Please read and answer each question carefully.

Mental Health History

Why are you seeking treatment? Depression Anxiety Substance Abuse
 Family Problems Relationship Issues Employment Issues
 Other (please describe)

Have you ever been hospitalized for psychiatric problems or chemical dependence? Yes No
If yes, please list below diagnosis, when, where, and by whom.

Have you ever been treated as an outpatient by a psychiatrist, therapist, counselor, or EAP? Yes No
If yes, please list diagnosis, when, and by whom.

Have you ever experienced a traumatic event or something that was extremely upsetting to you? Yes No
If yes, please describe.

Are you experiencing:

Depression:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Loss of interest in activities:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Loss or increase in appetite:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Significant weight loss or gain:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Increase or decrease in sleep:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Increase or decrease in energy level:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Feelings of worthlessness or guilt:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Problems in concentration or decision making:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Thoughts about death, suicide or self harm:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anxiety:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Panic or anxiety attacks:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fears:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Problems with binge eating:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Concerns about body image:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Persistent unpleasant thoughts:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Problems with repetitive behaviors:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Worries about physical health, finances, other:	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Have you ever experienced any of the following:

Periods of at least four days in which you were so happy or excited that you got into trouble or others became worried about you?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Periods of at least four days of irritability or temper problems:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Racing thoughts or feel like you can't keep up with your thoughts?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Thoughts that others are "out to get you":	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hallucinations (i.e. seeing, hearing, feeling, or smelling something that others cannot):	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Memory problems:	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Patient Name

Medical Records Chart #

Substance Use/Abuse History

How many times during the month do you consume alcohol?

How much do you drink each time?

Do you use any illegal drugs (Marijuana, Cocaine, Amphetamines, Heroin, other)?
If yes, please list below.

Yes No

Have you used any illegal drugs listed above in the past?
If yes, please list below, and time of last use.

Yes No

Have you ever abused prescription medications or over-the-counter medications such as pain medications, narcotics, anxiety medications, tranquilizers, or sleeping medications?
If yes, please describe below:

Yes No

Have you ever participated in NA/AA or other self-help program?

Yes No

How many caffeine products (colas or coffee) do you consume each day?

Do you use tobacco products?

Yes No

If yes, please describe below what you use and how much.

Family History

Is there any family history of any of the following :

high blood pressure Yes No

heart disease Yes No

diabetes Yes No

seizure disorder? Yes No

cancer Yes No

Is there any family history of mental conditions or chemical dependence such as :

depression Yes No

attention deficit disorder Yes No

manic-depressive/
(bipolar) disorder Yes No

anxiety disorders Yes No

schizophrenia Yes No

alcoholism Yes No

mental retardation Yes No

drug addiction Yes No

learning problems Yes No

suicide/suicide attempts Yes No

other (please describe) Yes No

Patient Name

Medical Records Chart #

Medical History

Please list any current medical problems and the name of your treating physician:

Please list all current psychiatric medications:

<u>Medication</u>	<u>Dosage/Size</u>	<u>How long</u>	<u>Reason/Effect</u>	<u>Prescribing Physician</u>
-------------------	--------------------	-----------------	----------------------	------------------------------

Please list all other current medications including prescription and over the counter:

<u>Medication</u>	<u>Dosage/Size</u>	<u>How long</u>	<u>Reason/Effect</u>	<u>Prescribing Physician</u>
-------------------	--------------------	-----------------	----------------------	------------------------------

Please list all past psychiatric medications?

<u>Medication</u>	<u>Dosage/Size</u>	<u>How long</u>	<u>Reason/Effect</u>	<u>Prescribing Physician</u>
-------------------	--------------------	-----------------	----------------------	------------------------------

Are you allergic to medications?

Yes No

If yes, please list below:

Have you ever experienced head trauma with loss of consciousness?

Yes No

Have you ever experienced seizures?

Yes No

If you are a woman, are you pregnant or plan to be?

Yes No Uncertain

Have you ever been hospitalized for major surgeries or illnesses?

Yes No

If yes, please list below diagnosis, when, where, and by whom.

Do you have a specific request or anything else that we should know about you to help make your treatment experience more successful?