Patient History Form

Date: _____/_____/_____

NAME: _____ Birthdate: _____/_____/_____
Last First Middle

Age:_____ Sex: ☐ F ☐ M

Please read the following questions and answer to the best of your ability by placing a check mark in the appropriate boxes or fill in the blank as directed.
YOUR COOPERATION IS APPRECIATED.

How did you hear about this clinic? OR Referred by: _____

PLEASE STATE IN YOUR OWN WORDS WHY YOU HAVE COME TO ALABAMA PSYCHIATRY AND COUNSELING: _____

PSYCHIATRIC HOSPITALIZATIONS (include where, when, & for what reason):
Yes ☐ **No** ☐

❑ **Have you ever had ECT?**	**Yes** ☐	**No** ☐
❑ **Have you had counseling?**	**Yes** ☐	**No** ☐

SYSTEMS REVIEW (PSYCHIATRIC)

PLEASE CHECK: In the past month, have you had any of the following problems?

- ☐ Felt sad or low? Sensitivity or Frequent crying?
- ☐ Felt upset or annoyed at little things?
- ☐ Had trouble enjoying things that used to be fun?
- ☐ Worried that you might hurt yourself or felt like you wanted to die?
- ☐ Had felt bad about yourself or that you are a failure or have let yourself or your family down?
- ☐ Felt Hopeless or Worthless?
- ☐ Had trouble falling or staying asleep?
- ☐ Sleeping too much?
- ☐ Had no appetite or been eating too much?
- ☐ Felt more tired than usual or have less energy?
- ☐ Trouble thinking, concentrating or making decisions?
- ☐ Moving or speaking so slowly that other people have noticed?
- ☐ Felt fidgety or restless that you have been moving around a lot more than usual?
- ☐ Felt like you have no one to talk to?
- ☐ Sexual problems?
- ☐ Gender concerns?
- ☐ Difficulties with sexual arousal?
- ☐ Had felt more self confident?
- ☐ Had felt more energetic and more active then usual?
- ☐ Had racing thoughts (thoughts jump from topic to topic)?
- ☐ Had taken more risks in your daily life? Work? or Other Activities?
- ☐ Felt driven to perform certain acts over and over, such as excessive checking, counting or arranging objects?
- ☐ Felt more nervous and anxious than usual?
- ☐ Worrying too much about different things?
- ☐ Unable to stop worrying?
- ☐ Had trouble relaxing?
- ☐ Felt like you are falling apart and going to pieces?
- ☐ Anxiety in social situation? Social phobia?
- ☐ I don't like my body?
- ☐ Intense fear of gaining weight?
- ☐ Excessive fasting to loose weight?
- ☐ Binge eating?
- ☐ Self-induced vomiting?
- ☐ Laxative abuse?
- ☐ Exposed to a significant traumatic event?
- ☐ Had recurrent distressing dreams / nightmares?
- ☐ Felt jumpy or easily startled by noises?
- ☐ Felt emotionally distant from others?
- ☐ Bothered by thoughts or images that repeatedly enter your mind such as concerns with contamination or keeping objects in perfect order?
- ☐ Hear voices or sounds that others do not hear?
- ☐ See things that others do not see?
- ☐ Smell things others don't smell?
- ☐ Paranoid or suspicious?
- ☐ Felt paranoid or suspicious such as being plotted against, followed or monitored?
- ☐ Memory problems / Forgetfullness?
- ☐ Use of drugs?
- ☐ Abuse of Alcohol?
- ☐ Smoke cigarettes?

SYSTEMS REVIEW (MEDICAL)

In the past month, have you had any of the following problems?

GENERAL

- ☐ Recent weight gain; how much____
- ☐ Recent weight loss: how much____
- ☐ Fatigue
- ☐ Weakness
- ☐ Fever
- ☐ Night sweats

MUSCLE/JOINTS/BONES

- ☐ Numbness
- ☐ Joint pain
- ☐ Muscle weakness
- ☐ Joint swelling

Where?

EARS

- ☐ Ringing in ears
- ☐ Loss of hearing

EYES

- ☐ Pain
- ☐ Redness
- ☐ Loss of vision
- ☐ Double or blurred vision
- ☐ Dryness

THROAT

- ☐ Frequent sore throats
- ☐ Hoarseness
- ☐ Difficulty in swallowing
- ☐ Pain in jaw

NERVOUS SYSTEM

- ☐ Headaches
- ☐ Dizziness
- ☐ Fainting or loss of consciousness
- ☐ Numbness or tingling
- ☐ Memory loss
- ☐ Seizure

STOMACH AND INTESTINES

- ☐ Nausea
- ☐ Heartburn
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Yellow jaundice
- ☐ Increasing constipation
- ☐ Persistent diarrhea
- ☐ Blood in stools
- ☐ Black stools

SKIN

- ☐ Redness
- ☐ Rash
- ☐ Nodules/bumps
- ☐ Hair loss
- ☐ Color changes of hands or feet

BLOOD

- ☐ Anemia
- ☐ Clots
- ☐ Excessive Bleeding

HEART AND LUNGS

- ☐ Chest Pain
- ☐ Palpitations
- ☐ Shortness of breath
- ☐ Fainting
- ☐ Swollen legs and feet

KIDNEY / BLADDER

- ☐ Frequent urination
- ☐ Burning on urination
- ☐ Blood in urine

WOMEN ONLY

- ☐ Abnormal papsmear
- ☐ Irregular periods
- ☐ Bleeding between periods
- ☐ PMS

OTHER PROBLEMS

- ☐
- ☐
- ☐
- ☐
- ☐
- ☐
- ☐
- ☐
- ☐
- ☐

PAST MEDICAL HISTORY

Do you now or have you ever had:

- ☐ Diabetes
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Hypothyroidism
- ☐ Goiter
- ☐ Cancer (type) _____
- ☐ Leukemia
- ☐ Psoriasis
- ☐ Angina
- ☐ Heart problems
- ☐ Heart murmur
- ☐ Pneumonia
- ☐ Pulmonary embolism
- ☐ Asthma
- ☐ Emphysema
- ☐ Stroke
- ☐ Epilepsy (seizures)
- ☐ Cataracts
- ☐ Kidney disease
- ☐ Kidney stones
- ☐ Crohn's disease
- ☐ Colitis
- ☐ Anemia
- ☐ Jaundice
- ☐ Hepatitis
- ☐ Stomach or peptic ulcer
- ☐ Rheumatic fever
- ☐ Tuberculosis
- ☐ HIV/AIDS

Other medical conditions (please list):

PERSONAL HISTORY

Do you now or have you ever had:

Where were your born & raised?

What is your highest education? ☐ High school ☐ Some college ☐ College graduate ☐ Advanced degree

Marital status: ☐ Never married ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Partnered/significant other

What is your current or past occupation?

Are you currently working? : ☐ Yes ☐ No

Hours/week _____ If not, are you ☐ retired ☐ disabled ☐ sick leave?

Do you receive disability or SSI? ☐ Yes ☐ No If yes, for what disability & how long?_____

Have you ever had legal problems? (specify)

CURRENT MEDICATIONS

Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:

Name of drug	Dose (strength & number of pills per day)	How long have you been taking this?

DRUG ALLEGIES

Drug allergies: ☐ No ☐ Yes To what?

PAST MEDICATIONS

Have you ever been on any of the following medications?

ANTIDEPRESSANTS

- ☐ Amitriptyline (Elavil)
- ☐ Notriptyline
- ☐ Imipramine
- ☐ Clomipramine (Anafranil)
- ☐ Desipramine
- ☐ Doxepin
- ☐ Amoxapine
- ☐ Fluoxetine (Prozac)
- ☐ Citalopram (Celexa)
- ☐ Escitalopram (Lexapro)
- ☐ Paroxetine (Paxil)
- ☐ Sertraline (Zoloft)
- ☐ Fluvoxamine (Luvox)
- ☐ Venlafaxine (Effexor)
- ☐ Desvenlafaxine (Pristiq)
- ☐ Duloxetine (Cymbalta)
- ☐ Vortioxetine (Brintellix)
- ☐ Vilazodone (Viibryd)
- ☐ Bupropion (Wellbutrin)
- ☐ Mirtazapine (Remeron)
- ☐ Phenelzineu (Nardil)

MOOD STABALIZERS

- ☐ Valproic Acid (Depakote)
- ☐ Lamotrigine (Lamictal)
- ☐ Carbamazepine (Tegretol)
- ☐ Oxcarbazepine (Trileptal)
- ☐ Topiramate (Topamax
- ☐ Gabapentin (Neurontin)
- ☐ Lithium

ANXIETY MEDICATIONS

- ☐ Alprazolam (Xanax)
- ☐ Clonazepam (Klonopin)
- ☐ Lorazepam (Ativan)
- ☐ Diazepam (Valium)
- ☐ Chlordiazepoxide (Librium)
- ☐ Oxazepam (Serax)
- ☐ Hydroxyzine (Vistaril)
- ☐ Buspirone (Buspar)
- ☐ Pregabalin (Lyrica)

ANTIPSYCHOTICS

- ☐ Risperidone (Risperdal)
- ☐ Quetiapine (Seroquel)
- ☐ Olanzapine (Zyprexa)
- ☐ Ziprasidone (Geodon)
- ☐ Clozapine (Clozaril)
- ☐ Aripiprazole (Abilify)
- ☐ Paliperidone (Invega)
- ☐ Asenapine (Saphris)
- ☐ Iloperidone (Fanapt)
- ☐ Caripraszine (Vraylar)
- ☐ Brexpiprazole (Rexulti)
- ☐ Haloperidol (Haldol)
- ☐ Fluphenazine (Prolixin)
- ☐ Pimozide (Orap)
- ☐ Chlorpromazine (Thorazine)
- ☐ Perphenazine (Trilafon)
- ☐ Thioridazine
- ☐ Thiothixene (Navane)
- ☐ Trifluoperazine (Stelazine)

ADHD MEDICATIONS

- ☐ Adderall
- ☐ Vyvanse
- ☐ Dexedrine
- ☐ Methylphenidate (Ritalin)
- ☐ Concerta
- ☐ Focalin
- ☐ Adzenys XR (Amphetamine)
- ☐ Metadate (Methylphenidate)
- ☐ Bupropion (Wellbutrin)
- ☐ Atomoxetine (Strattera)
- ☐ Clonidine (Catapress)
- ☐ Guanfacine (Tenex; Intuniv)

SLEEP MEDICATIONS

- ☐ Trazodone
- ☐ Zolpidem (Ambien)
- ☐ Zaleplon (Sonata)
- ☐ Eszopiclone (Lunesta)
- ☐ Ramelteon
- ☐ Triazolam (Halcion)
- ☐ Temazepam (Restoril)

SUBSTANCE USE TREATMENT

- ☐ Methadone
- ☐ Buprenorphine (Subutex)
- ☐ Disulfiram (Antabuse
- ☐ Naltrexone (Vivitrol)
- ☐ Bupropion (Zyban)
- ☐ Varenicline (Chantix)
- ☐ Acamprosate (Campra)

SUBSTANCE USE

DRUG CATEGORY	Do you currently use this?	Comments
ALCOHOL	Yes☐ No☐	
CANNABIS: Marijuana, hashish, hash oil	Yes☐ No☐	
STIMULANTS: Cocaine, crack	Yes☐ No☐	
STIMULANTS: Methamphetamine—speed, ice, crank	Yes☐ No☐	
AMPHETAMINES/OTHER STIMULANTS: Ritalin, Benzedrine, Dexedrine	Yes☐ No☐	
BENZODIAZEPINES/TRANQUILIZERS: Valium, Librium, Halcion, Xanax, Diazepam, “Roofies”	Yes☐ No☐	
SEDATIVES/HYPNOTICS/BARBITURATES: Amytal, Seconal, Dalmane, Quaalude, Phenobarbital	Yes☐ No☐	
HEROIN	Yes☐ No☐	
STREET OR ILLICIT METHADONE	Yes☐ No☐	
OTHER OPIOIDS: Tylenol #2 & #3, 282’S, 292’S, Percodan, Percocet, Opium, Morphine, Demerol, Dilaudid	Yes☐ No☐	
HALLUCINOGENS: LSD, PCP, STP, MDA, DAT, mescaline, peyote, mushrooms, ecstasy (MDMA), nitrous oxide	Yes☐ No☐	
INHALANTS: Glue, gasoline, aerosols, paint thinner, poppers, rush, locker room	Yes☐ No☐	
OTHER: specify)_____ _____	Yes☐ No☐	

FAMILY HISTORY

Please list all blood relatives who have been diagnosed with the following conditions:

Depression / Major Depression /Suicide

Anxiety Disorders

Bipolar Disorders

Schizophrenia / Schizoaffective Disorder / Psychotic Disorders

Alcoholism

Drug Abuse

Heart disease, high blood pressure, arrhythmias

Diabetes

Seizure

Stroke

Thyroid Disorders

Cancer

OTHER