

| Patient History Form   |  |              |             |             |  |  |
|--|--|--------------|-------------|-------------|--|--|
| Dat  | e://   |              |             |             |  |  |
|  | ME:Last  |              | Middle      | Birthdate:/ |  |  |
| Age  | 9:   |              |             | Sex: F M    |  |  |
| ch   | 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. |              |             |             |  |  |
| Но   | w did you hear about thi   | s clinic? OR | Referred by | <b>/</b> :  |  |  |
|  |  |              |             |             |  |  |
|  |  |              |             |             |  |  |
|  | 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 ECT2   |              | Voc         | No          |  |  |
|  | Have you ever had ECT?  Have you had counseling?   |              | Yes<br>Yes  | No No       |  |  |

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

## **SYSTEMS REVIEW (MEDICAL)** In the past month, have you had any of the following problems? **GENERAL NERVOUS SYSTEM HEART AND LUNGS** ☐ Recent weight gain; how much\_\_\_\_ ☐ Headaches ☐ Chest Pain ☐ Recent weight loss: how much\_\_\_\_ □ Dizziness Palpitations □ Fatigue ☐ Fainting or loss of consciousness ☐ Shortness of breath ■ Weakness ■ Numbness or tingling □ Fainting □ Fever ■ Memory loss ■ Swollen legs and feet ■ Night sweats □ Seizure MUSCLE/JOINTS/BONES STOMACH AND INTESTINES **KIDNEY / BLADDER** ■ Numbness ■ Nausea ☐ Frequent urination Joint pain ☐ Heartburn ■ Burning on urination ■ Muscle weakness □ Blood in urine ☐ Stomach pain ■ Joint swelling Vomiting Where? ☐ Yellow jaundice **WOMEN ONLY** ☐ Increasing constipation ■ Abnormal papsmear **EARS** ☐ Persistent diarrhea ☐ Irregular periods ■ Blood in stools ☐ Bleeding between periods ☐ Ringing in ears □Loss of hearing □ Black stools □ PMS **EYES SKIN OTHER PROBLEMS** ☐ Pain □ Redness □ Redness □ Rash ☐ Loss of vision ■ Nodules/bumps ☐ Double or blurred vision ☐ Hair loss □ Dryness ☐ Color changes of hands or feet **BLOOD THROAT** ☐ Frequent sore throats □ Anemia □ Hoarseness □ Clots ☐ Difficulty in swallowing ■ Excessive Bleeding □ Pain in jaw

| PAST MEDICAL HISTORY   |                                      |                           |  |  |  |
|--|--------------------------------------|---------------------------|--|--|--|
| Do you now or have you ever had:   |                                      |                           |  |  |  |
|  |                                      |                           |  |  |  |
| □ Diabetes   | ☐ Heart murmur                       | ☐ Crohn's disease         |  |  |  |
| ☐ High blood pressure  | □ Pneumonia                          | ☐ Colitis                 |  |  |  |
| ☐ High cholesterol   | ☐ Pulmonary embolism                 | □ Anemia                  |  |  |  |
| ☐ Hypothyroidism   | ☐ Asthma                             | ☐ Jaundice                |  |  |  |
| □ Goiter   | □ Emphysema                          | ☐ Hepatitis               |  |  |  |
| ☐ Cancer (type)  | ☐ Stroke                             | ☐ Stomach or peptic ulcer |  |  |  |
| □ Leukemia   | ☐ Epilepsy (seizures)                | ☐ Rheumatic fever         |  |  |  |
| ☐ Psoriasis  | ☐ Cataracts                          | ☐ Tuberculosis            |  |  |  |
| □ Angina   | ☐ Kidney disease                     | ☐ HIV/AIDS                |  |  |  |
| ☐ Heart problems   | ☐ Kidney stones                      |                           |  |  |  |
| 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 ☐ I  | No If yes, for what disability & how | v long?                   |  |  |  |

Have you ever had legal problems? (specify)

Phone: (205)440-6292

| CURRENT MEDICATIONS  |                  |   |      |  |  |
|--|------------------|---|------|--|--|
| Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements: |                  |   |      |  |  |
| Name of drug   | th & number of p | number of pills per day) How long have you be |      |  |  |
|  |                  |   |      |  |  |
|  |                  |   |      |  |  |
|  |                  |   |      |  |  |
|  |                  |   |      |  |  |
|  |                  |   |      |  |  |
|  |                  |   |      |  |  |
|  |                  |   |      |  |  |
|  |                  |   |      |  |  |
|  |                  |   |      |  |  |
|  |                  |   |      |  |  |
|  |                  |   |      |  |  |
|  |                  |   |      |  |  |
|  |                  |   |      |  |  |
|  |                  |   |      |  |  |
|  |                  |   |      |  |  |
|  |                  |   |      |  |  |
|  |                  |   |      |  |  |
|  |                  | DRUG ALLE                                     | GIES |  |  |
| Drug allergies: ☐ No ☐ Ye  | es To what?      |   |      |  |  |
|  |                  |   |      |  |  |
|  |                  |   |      |  |  |
|  |                  |   |      |  |  |
|  |                  |   |      |  |  |
|  |                  |   |      |  |  |
|  |                  |   |      |  |  |
|  |                  |   |      |  |  |

| PAST MEDICATIONS  |                               |                               |  |  |  |
|---|-------------------------------|-------------------------------|--|--|--|
| Have you ever been on any of the following medications? |                               |                               |  |  |  |
| ANTIDEPRESSANTS   | ANXIETY MEDICATIONS           | ADHD MEDICATIONS              |  |  |  |
| ☐ Amitriptyline (Elavil)                                | ☐ Alprazolam (Xanax)          | ☐ Adderall                    |  |  |  |
| ☐ Notriptyline  | ☐ Clonazepam (Klonopin)       | ☐ Vyvanse                     |  |  |  |
| ☐ Imipramine  | ☐ Lorazepam (Ativan)          | ☐ Dexedrine                   |  |  |  |
| ☐ Clomipramine (Anafranil)                              | ☐ Diazepam (Valium)           | ☐ Methylphenidate (Ritalin)   |  |  |  |
| ☐ Desipramine   | ☐ Chlordiazepoxide (Librium)  | □ Concerta                    |  |  |  |
| ☐ Doxepin   | ☐ Oxazepam (Serax)            | □ Focalin                     |  |  |  |
| ☐ Amoxapine   | ☐ Hydroxyzine (Vistaril)      | ☐ Adzenys XR (Amphetamine)    |  |  |  |
| ☐ Fluoxetine (Prozac)                                   | ☐ Buspirone (Buspar)          | ☐ Metadate (Methylphenidate)  |  |  |  |
| ☐ Citalopram (Celexa)                                   | ☐ Pregabalin (Lyrica)         | ☐ Bupropion (Wellbutrin)      |  |  |  |
| ☐ Escitalopram (Lexapro)                                |                               | ☐ Atomoxetine (Strattera)     |  |  |  |
| ☐ Paroxetine (Paxil)                                    | ANTIPSYCHOTICS                | ☐ Clonidine (Catapress)       |  |  |  |
| ☐ Sertraline (Zoloft)                                   | ☐ Risperidone (Risperdal)     | ☐ Guanfacine (Tenex; Intuniv) |  |  |  |
| ☐ Fluvoxamine (Luvox)                                   | ☐ Quetiapine (Seroquel)       |                               |  |  |  |
| ☐ Venlafaxine (Effexor)                                 | ☐ Olanzapine (Zyprexa)        | SLEEP MEDICATIONS             |  |  |  |
| ☐ Desvenlafaxine (Pristiq)                              | ☐ Ziprasidone (Geodon)        | ☐ Trazodone                   |  |  |  |
| ☐ Duloxetine (Cymbalta)                                 | ☐ Clozapine (Clozaril)        | ☐ Zolpidem (Ambien)           |  |  |  |
| ☐ Vortioxetine (Brintellix)                             | ☐ Aripiprazole (Abilify)      | ☐ Zaleplon (Sonata)           |  |  |  |
| ☐ Vilazodone (Viibryd)                                  | ☐ Paliperidone (Invega)       | ☐ Eszopiclone (Lunesta)       |  |  |  |
| ☐ Bupropion (Wellbutrin)                                | ☐ Asenapine (Saphris)         | □ Ramelteon                   |  |  |  |
| ☐ Mirtazapine (Remeron)                                 | ☐ Iloperidone (Fanapt)        | ☐ Triazolam (Halcion)         |  |  |  |
| ☐ Phenelzineu (Nardil)                                  | ☐ Caripraszine (Vraylar)      | ☐ Temazepam (Restoril)        |  |  |  |
|   | ☐ Brexpiprazole (Rexulti)     |                               |  |  |  |
| MOOD STABALIZERS  | ☐ Haloperidol (Haldol)        | SUBSTANCE USE TREATMENT       |  |  |  |
| ☐ Valproic Acid (Depakote)                              | ☐ Fluphenazine (Prolixin)     | ☐ Methadone                   |  |  |  |
| ☐ Lamotrigine (Lamictal)                                | ☐ Pimozide (Orap)             | ☐ Buprenorphine (Subutex)     |  |  |  |
| ☐ Carbamazepine (Tegretol)                              | ☐ Chlorpromazine (Thorazine)  | ☐ Disulfiram (Antabuse        |  |  |  |
| ☐ Oxcarbazepine (Trileptal)                             | ☐ Perphenazine (Trilafon)     | ☐ Naltrexone (Vivitrol)       |  |  |  |
| ☐ Topiramate (Topamax                                   | ☐ Thioridazine                | ☐ Bupropion (Zyban)           |  |  |  |
| ☐ Gabapentin (Neurontin)                                | ☐ Thiothixene (Navane)        | ☐ Varenicline (Chantix)       |  |  |  |
| □ Lithium   | ☐ Trifluoperazine (Stelazine) | ☐ 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  |
|  |