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Clinical History

Date: ______ /_______ /_______

Client Name: ___________________________________ DOB: ______ /_______ /_______

Identified Gender: ▢ Male ▢ Female ▢ Other

Stressors

Instruction: If you are filling this out on behalf of the patient, please answer from the patient's perspective.

Given the list of categories below, how much stress is each currently causing you?

	None	Mild Stress	Moderate Stress	Severe Stress
Family	▢	▢	▢	▢
Friends	▢	▢	▢	▢
Relationships	▢	▢	▢	▢
Educational	▢	▢	▢	▢
Economic	▢	▢	▢	▢
Occupational	▢	▢	▢	▢
Housing	▢	▢	▢	▢
Legal	▢	▢	▢	▢
Health	▢	▢	▢	▢

Substance Abuse History

Instruction: If you are filling this out on behalf of the patient, please answer from the patient's perspective.

Substance(s) Used:	Yes	No	Age of First Use	Age of Last Use	How was it taken?			
Amphetamines / Speed	○	○	_______	_______	▢ Oral	▢ Nasal	▢ Inhaled	▢ Injected
Barbiturates / Downers	○	○	_______	_______	▢ Oral	▢ Nasal	▢ Inhaled	▢ Injected

Substance(s) Used:	Yes	No	Age of First Use	Age of Last Use	How was it taken?
Opiates	○	○	________	________	Oral Nasal Inhaled Injected
Cocaine	○	○	________	________	Oral Nasal Inhaled Injected
Psychedelics (e.g. LSD, Ecstasy, bath salts)	○	○	________	________	Oral Nasal Inhaled Injected

Substance(s) Used:	Yes	No	Age of First Use	Age of Last Use	How was it taken?
Inhalants (e.g. glue, aerosols)	○	○	________	________	Oral Nasal Inhaled Injected
Cannabis / Marijuana / Hashish	○	○	________	________	Oral Nasal Inhaled Injected
Benzodiazepines	○	○	________	________	Oral Nasal Inhaled Injected
PCP	○	○	________	________	Oral Nasal Inhaled Injected
Other:____________________	○	○	________	________	Oral Nasal Inhaled Injected
Other:____________________	○	○	________	________	Oral Nasal Inhaled Injected

---

Substance Abuse Treatment History

Instruction: If you are filling out on behalf of the patient, please answer from the patient's perspective.

Did you receive any treatment for substance abuse?

- Yes
- No

If you answered "no," skip the rest of this section.

Treatment Type	Yes	No	How many episodes of	Age of first treatment?	Age of last treatment?	Additional comments:

			treatment?		
Inpatient	○	○	________	________	________
Intensive Outpatient	○	○	________	________	________
Outpatient	○	○	________	________	________
12-Step Program	○	○	________	________	________
Other:____________________	○	○	________	________	________
Other:____________________	○	○	________	________	________

Consequences of Substance Abuse

Instruction: If you are filling this out on behalf of the patient, please answer from the patient's perspective.

Have you experienced any of these consequences as a result of alcohol consumption or abuse of substances? (Please check all that apply, continued on next page)

- ☐ No consequences
- ☐ Felt that you needed to cut down on your drinking
- ☐ Been annoyed by others criticizing your drinking
- ☐ Felt guilty about drinking
- ☐ Needing a drink first thing in the morning
- ☐ Effects on physical health
- ☐ Using/consuming more than intended
- ☐ Unintentional overdose
- ☐ DUI
- ☐ Arrests
- ☐ Increased tolerance
- ☐ Withdrawal (shakes, sweating, nausea, rapid heart rate)
- ☐ Seizures
- ☐ Blackouts
- ☐ Physical fights or assaults
- ☐ Relationship conflicts
- ☐ Problems with money
- ☐ Job loss or problems at work/school

Other: ____

Inpatient Psychiatric History

Instruction: If you are filling this out on behalf of the patient, please answer from the patient's perspective.

Do you have a history of inpatient psychiatric treatment?

- ☐ Yes

■ No

If you answered "no," skip the rest of this section.

Please list any past inpatient treatment history below. Start with the most recent and list each episode of treatment separately.

1. Hospital / Facility: ____

   Treatment Voluntary: ☐ Yes ☐ No How old were you? _____

   Primary reason for hospitalization (select one):

   ■ Depression ■ Manic Episode ☐ Drug / Alcohol Related
   ☐ Suicidal Thoughts ■ Psychotic Episode ☐ Assault
   ☐ Suicide Attempt ☐ Severe Anxiety ■ Violence

   Treatment Outcome:

   ■ Feeling Worse or Negative Result
   ☐ Minor Improvement or No effect (0 - 24%)
   ☐ Partial Response (25% - 49%)
   ■ Significant Improvement (50% - 74%)
   ■ Resolved or Nearly Resolved Problem (75% - 100%)

   Additional comments:

   ____

   ____

2. Hospital / Facility: ____

   Treatment Voluntary: ☐ Yes ☐ No How old were you? _____

   Primary reason for hospitalization (select one):

   ☐ Depression ■ Manic Episode ☐ Drug / Alcohol Related
   ■ Suicidal Thoughts ☐ Psychotic Episode ■ Assault
   ☐ Suicide Attempt ☐ Severe Anxiety ■ Violence

   Treatment Outcome:

   ☐ Feeling Worse or Negative Result
   ☐ Minor Improvement or No effect (0 - 24%)
   ☐ Partial Response (25% - 49%)
   ☐ Significant Improvement (50% - 74%)
   ☐ Resolved or Nearly Resolved Problem (75% - 100%)

   Additional comments:

   ____

   ____

3. Hospital / Facility: ____

   Treatment Voluntary: ☐ Yes ☐ No How old were you? _____

   Primary reason for hospitalization (select one):

   ☐ Depression ■ Manic Episode ☐ Drug / Alcohol Related
   ☐ Suicidal Thoughts ☐ Psychotic Episode ☐ Assault
   ☐ Suicide Attempt ☐ Severe Anxiety ☐ Violence

Treatment Outcome:

- ☐ Feeling Worse or Negative Result
- ☐ Minor Improvement or No effect (0 - 24%)
- ☐ Partial Response (25% - 49%)
- ☐ Significant Improvement (50% - 74%)
- ☐ Resolved or Nearly Resolved Problem (75% - 100%)

Additional comments:

____

____

Outpatient Psychiatric History

Instruction: If you are filling this out on behalf of the patient, please answer from the patient's perspective.

Do you have a history of outpatient psychiatric treatment?

☐ Yes

☐ No

If you answered "no," skip the rest of this section.

Please list any past outpatient treatment history below. Start with the most recent and list each episode of treatment separately.

1. Provider: ____

   Age of First Treatment: _____ Age of Last Treatment: _____

   Primary reason for seeking treatment (select one):

   - ☐ Depression
   - ☐ Social Anxiety Disorder
   - ☐ Eating Disorder
   - ☐ Obsessive Compulsive Disorder
   - ☐ Panic Disorder
   - ☐ Alcoholism
   - ☐ Generalized Anxiety Disorder
   - ☐ Bipolar Disorder
   - ☐ Drug Abuse
   - ☐ Post Traumatic Stress Disorder
   - ☐ ADHD
   - ☐ Personality Disorder
   - ☐ Disruptive Behavior Problems
   - ☐ Autism Spectrum Disorder
   - ☐ Suicide
   - ☐ Schizophrenia / Psychosis

   Treatment Outcome:

   - ☐ Feeling Worse or Negative Result
   - ☐ Minor Improvement or No effect (0 - 24%)
   - ☐ Partial Response (25% - 49%)
   - ☐ Significant Improvement (50% - 74%)
   - ☐ Resolved or Nearly Resolved Problem (75% - 100%)

   Additional comments:

   ____

____

2. Provider: ____

   Age of First Treatment: _____ Age of Last Treatment: _____

   Primary reason for seeking treatment (select one):

   - ☐ Depression
   - ☐ Obsessive Compulsive Disorder
   - ☐ Generalized Anxiety Disorder
   - ☐ Post Traumatic Stress Disorder
   - ☐ Disruptive Behavior Problems
   - ☐ Schizophrenia / Psychosis
   - ☐ Social Anxiety Disorder
   - ☐ Panic Disorder
   - ☐ Bipolar Disorder
   - ☐ ADHD
   - ☐ Autism Spectrum Disorder
   - ☐ Eating Disorder
   - ☐ Alcoholism
   - ☐ Drug Abuse
   - ☐ Personality Disorder
   - ☐ Suicide

   Treatment Outcome:

   - ☐ Feeling Worse or Negative Result
   - ☐ Minor Improvement or No effect (0 - 24%)
   - ☐ Partial Response (25% - 49%)
   - ☐ Significant Improvement (50% - 74%)
   - ☐ Resolved or Nearly Resolved Problem (75% - 100%)

   Additional comments:

   ____

   ____

3. Provider: ____

   Age of First Treatment: _____ Age of Last Treatment: _____

   Primary reason for seeking treatment (select one):

   - ☐ Depression
   - ☐ Obsessive Compulsive Disorder
   - ☐ Generalized Anxiety Disorder
   - ☐ Post Traumatic Stress Disorder
   - ☐ Disruptive Behavior Problems
   - ☐ Schizophrenia / Psychosis
   - ☐ Social Anxiety Disorder
   - ☐ Panic Disorder
   - ☐ Bipolar Disorder
   - ☐ ADHD
   - ☐ Autism Spectrum Disorder
   - ☐ Eating Disorder
   - ☐ Alcoholism
   - ☐ Drug Abuse
   - ☐ Personality Disorder
   - ☐ Suicide

   Treatment Outcome:

   - ☐ Feeling Worse or Negative Result
   - ☐ Minor Improvement or No effect (0 - 24%)
   - ☐ Partial Response (25% - 49%)
   - ☐ Significant Improvement (50% - 74%)
   - ☐ Resolved or Nearly Resolved Problem (75% - 100%)

   Additional comments:

   ____

   ____

Suicide / Self-Harm History

Instruction: If you are filling this out on behalf of the patient, please answer from the patient's perspective.

Have you ever tried to harm or kill yourself?

☐ Yes ☐ No

If you answered "no," skip the rest of this section.

Was your intent to die?

☐ Yes ☐ No

Elaborate, if desired:

____

____

____

______

How many times in your life has this occurred? __________

Most Severe Episode

Please describe your most *severe* episode including date, method and consequences:

Month: _____________________ Year: __________

Method (select one):

- ☐ Overdose
- ☐ Drowning
- ☐ Jumping in front of vehicle
- ☐ Cutting / Stabbing
- ☐ Hanging
- ☐ Carbon monoxide
- ☐ Gunshot
- ☐ Jumping from height
- ☐ Suffocation
- ☐ Other:

Consequences (select one):

- ☐ No medical treatment
- ☐ Outpatient medical visit
- ☐ Emergency Room (ER)
- ☐ Hospital Admission
- ☐ Intensive Care Unit (ICU)
- ☐ Other:

Most Recent Episode

Please describe your most *recent* episode including date, method and consequences:

Month: ______________________ Year: ___________

Method (select one):

- [x] Overdose
- [x] Drowning
- [ ] Jumping in front of vehicle
- [x] Cutting / Stabbing
- [x] Hanging
- [ ] Carbon monoxide
- [ ] Gunshot
- [ ] Jumping from height
- [ ] Suffocation
- [ ] Other:

Consequences (select one):

- [x] No medical treatment
- [ ] Outpatient medical visit
- [ ] Emergency Room (ER)
- [ ] Hospital Admission
- [ ] Intensive Care Unit (ICU)
- [x] Other:

Violence History Assessment

Instruction: If you are filling this out on behalf of the patient, please answer from the patient's perspective.

Have you ever had any history of violent behavior?

○ Yes ○ No

If you answered "no," skip the rest of this section.

If *yes*, please elaborate:

____

____

____

____

Past Medical History

Instruction: If you are filling this out on behalf of the patient, please answer from the patient's perspective.

Who is your primary care physician? ____

Are you taking any medications currently? (Excluding medications for psychiatric treatment)

- [ ] Yes
- [x] No

If *yes*, please list these medications:

Have you a history of any of the following health problems? (Please check all that apply)

- [ ] No problems
- [x] Allergies
- [ ] Anemia (low blood count)
- [ ] Arthritis
- [ ] Asthma
- [ ] Back problems (including disk or spine)
- [ ] Cancer
- [ ] Cataracts
- [ ] Chickenpox (as a child)
- [ ] Chronic Bronchitis
- [ ] COPD (Emphysema)
- [ ] Diabetes
- [ ] Diverticulitis
- [ ] Fainting spells / Passing out
- [x] High cholesterol
- [ ] Fibromyalgia
- [ ] Gall Bladder disease
- [ ] Gastritis or Ulcer
- [ ] Glaucoma
- [ ] Gout
- [ ] Hearing loss
- [ ] Heart disease
- [ ] Heart defect from birth
- [ ] Heart valve problems
- [ ] Hemorrhoids
- [x] Hepatitis
- [ ] Hernia
- [ ] HIV
- [x] Hypertension (high blood pressure)
- [ ] Hypotension (low blood pressure)
- [ ] Inflammatory bowel disease
- [x] Iron deficiency
- [ ] Kidney disease
- [ ] Kidney stones
- [ ] Liver disease (other)
- [ ] Lupus
- [ ] Migraine headaches
- [ ] Multiple Sclerosis
- [ ] Obesity / Overweight
- [x] Parkinson's disease
- [ ] Polyps
- [ ] Seizures
- [ ] Sexually Transmitted Disease
- [ ] Sleep apnea
- [x] Stroke / TIA
- [x] Testosterone (low)
- [ ] Thyroid problems
- [ ] Tuberculosis
- [ ] Other:

Have you a history of surgery in any of the following areas? (Please check all that apply)

- [ ] No surgical history
- [ ] Back / Neck
- [ ] Brain
- [ ] Hip / Knee / Ankle / Foot
- [ ] Hysterectomy (ovaries removed)
- [ ] Hysterectomy (ovaries retained)
- [ ] Intestine
- [ ] Penis
- [ ] Prostate
- [ ] Sex change
- [x] Shoulder / Elbow/ Wrist / Hand

Sugical history, continued:

- [ ] Cardiac
- [ ] Ear / Nose / Throat
- [x] Gall Bladder
- [x] Hernia
- [ ] Kidney
- [ ] Liver
- [ ] Lung
- [ ] Pancreas
- [ ] Pelvis
- [ ] Stomach
- [ ] Tonsils
- [ ] Vagina
- [ ] Weight loss
- [ ] Other:

Psychiatric Medication History

Instruction: If you are filling out this on behalf of the patient, please answer from the patient's perspective.

Have you ever taken any medication for psychiatric treatment?

○ Yes ○ No

If NO, skip the rest of this section.

If YES, please fill out the information below to the best of your knowledge:

1. Medication Name: ____

Dosage: ______________________ For how long? (months) __________ End Date: ____ / ____ / ______

Side Effects: ____

Reason for stopping? ____

Therapeutic Effect:

- ☐ Feeling Worse or Negative Result
- ☐ Minor Improvement or No effect (0 - 24%)
- ☐ Partial Response (25% - 49%)
- ☒ Significant Improvement (50% - 74%)
- ☐ Resolved or Nearly Resolved Problem (75% - 100%)

2. Medication Name: ____

Dosage: ______________________ For how long? (months) __________ End Date: ____ / ____ / ______

Side Effects: ____

Reason for stopping? ____

Therapeutic Effect:

- ☐ Feeling Worse or Negative Result
- ☐ Minor Improvement or No effect (0 - 24%)
- ☐ Partial Response (25% - 49%)
- ☐ Significant Improvement (50% - 74%)
- ☐ Resolved or Nearly Resolved Problem (75% - 100%)

3. Medication Name: ____

Dosage: ______________________ For how long? (months) __________ End Date: ____ / ____ / ______

Side Effects: ____

Reason for stopping? ____

Therapeutic Effect:

- ☐ Feeling Worse or Negative Result
- ☒ Minor Improvement or No effect (0 - 24%)
- ☐ Partial Response (25% - 49%)

- [ ] Significant Improvement (50% - 74%)
- [x] Resolved or Nearly Resolved Problem (75% - 100%)

4. Medication Name: ____

Dosage: _____________________ For how long? (months) __________ End Date: ____ / ____ / ______

Side Effects: ____

Reason for stopping? ____

Therapeutic Effect:

- [ ] Feeling Worse or Negative Result
- [x] Minor Improvement or No effect (0 - 24%)
- [x] Partial Response (25% - 49%)
- [ ] Significant Improvement (50% - 74%)
- [ ] Resolved or Nearly Resolved Problem (75% - 100%)

5. Medication Name: ____

Dosage: _____________________ For how long? (months) __________ End Date: ____ / ____ / ______

Side Effects: ____

Reason for stopping? ____

Therapeutic Effect:

- [x] Feeling Worse or Negative Result
- [ ] Minor Improvement or No effect (0 - 24%)
- [ ] Partial Response (25% - 49%)
- [ ] Significant Improvement (50% - 74%)
- [ ] Resolved or Nearly Resolved Problem (75% - 100%)

6. Medication Name: ____

Dosage: _____________________ For how long? (months) __________ End Date: ____ / ____ / ______

Side Effects: ____

Reason for stopping?

____

Therapeutic Effect:

- ☐ Feeling Worse or Negative Result
- ☐ Minor Improvement or No effect (0 - 24%)
- ☐ Partial Response (25% - 49%)
- ☐ Significant Improvement (50% - 74%)
- ■ Resolved or Nearly Resolved Problem (75% - 100%)

++

7. Medication Name: ____

Dosage: ______________________ For how long? (months) __________ End Date: ____ / ____ / ______

Side Effects:

____

Reason for stopping?

____

Therapeutic Effect:

- ■ Feeling Worse or Negative Result
- ☐ Minor Improvement or No effect (0 – 24%)
- ■ Partial Response (25% - 49%)
- ☐ Significant Improvement (50% - 74%)
- ☐ Resolved or Nearly Resolved Problem (75% - 100%)

8. Medication Name: ____

Dosage: ______________________ For how long? (months) __________ End Date: ____ / ____ / ______

Side Effects:

____

Reason for stopping?

____

Therapeutic Effect:

- ☐ Feeling Worse or Negative Result
- ■ Minor Improvement or No effect (0 – 24%)
- ☐ Partial Response (25% - 49%)
- ☐ Significant Improvement (50% - 74%)
- ☐ Resolved or Nearly Resolved Problem (75% - 100%)

9. Medication Name: ____

Dosage: ______________________ For how long? (months) __________ End Date: ____ / ____ / ______

Side Effects: ____

Reason for stopping? ____

Therapeutic Effect:

- ☒ Feeling Worse or Negative Result
- ☒ Minor Improvement or No effect (0 – 24%)
- ☐ Partial Response (25% - 49%)
- ☐ Significant Improvement (50% - 74%)
- ☐ Resolved or Nearly Resolved Problem (75% - 100%)

10. Medication Name: ____

Dosage: ______________________ For how long? (months) __________ End Date: ____ / ____ / ______

Side Effects: ____

Reason for stopping? ____

Therapeutic Effect:

- ☐ Feeling Worse or Negative Result
- ☐ Minor Improvement or No effect (0 – 24%)
- ☐ Partial Response (25% - 49%)
- ☐ Significant Improvement (50% - 74%)
- ☐ Resolved or Nearly Resolved Problem (75% - 100%)

Patient Allergies

Instruction: If you are filling this out on behalf of the patient, please answer from the patient's perspective.

Do you have any known allergies to medication?

☐ Yes ☐ No

If NO, please skip the rest of this section.
If YES, please fill out your allergy information below:

Medication Allergy	Allergic Reaction
1.	
2.	
3.	

4.	
5.	

Family History

Instruction: If you are filling this out on behalf of the patient, please answer from the patient's perspective.

Family Psychiatric History

Do you have any family members with a history of psychiatric illness?

☐ Yes ☐ No

If YES, please elaborate below:

☐ Mother ☑ Father ☐ Grandmother ☐ Grandfather ☐ Sister
☐ Brother ☑ Daughter ☐ Son ☐ Aunt ☐ Uncle
☐ Cousin

1. Family member:

Psychiatric Problem(s):

☐ Depression ☑ Social Anxiety Disorder ☐ Eating Disorder
☑ Obsessive Compulsive Disorder ☐ Panic Disorder ☐ Alcoholism
☐ Generalized Anxiety Disorder ☐ Bipolar Disorder ☐ Drug Abuse
☐ Post Traumatic Stress Disorder ☐ ADHD ☑ Personality Disorder
☐ Disruptive Behavior Problems ☑ Autism Spectrum Disorder ☐ Suicide
☐ Schizophrenia / Psychosis ☐ Suicide Attempt

☐ Mother ☐ Father ☐ Grandmother ☐ Grandfather ☑ Sister
☐ Brother ☐ Daughter ☐ Son ☐ Aunt ☐ Uncle
☐ Cousin

2. Family member:

Psychiatric Problem(s):

☑ Depression ☐ Social Anxiety Disorder ☐ Eating Disorder
☐ Obsessive Compulsive Disorder ☐ Panic Disorder ☐ Alcoholism
☐ Generalized Anxiety Disorder ☑ Bipolar Disorder ☐ Drug Abuse

- [ ] Post Traumatic Stress Disorder
- [x] ADHD
- [x] Personality Disorder
- [x] Disruptive Behavior Problems
- [x] Autism Spectrum Disorder
- [ ] Suicide
- [ ] Schizophrenia / Psychosis
- [ ] Suicide Attempt

- [ ] Mother
- [x] Father
- [ ] Grandmother
- [ ] Grandfather
- [ ] Sister
- [x] Brother
- [ ] Daughter
- [ ] Son
- [x] Aunt
- [ ] Uncle
- [ ] Cousin

3. Family member:

Psychiatric Problem(s):

- [ ] Depression
- [x] Social Anxiety Disorder
- [x] Eating Disorder
- [ ] Obsessive Compulsive Disorder
- [x] Panic Disorder
- [x] Alcoholism
- [ ] Generalized Anxiety Disorder
- [ ] Bipolar Disorder
- [ ] Drug Abuse
- [x] Post Traumatic Stress Disorder
- [ ] ADHD
- [x] Personality Disorder
- [ ] Disruptive Behavior Problems
- [ ] Autism Spectrum Disorder
- [ ] Suicide
- [ ] Schizophrenia / Psychosis
- [ ] Suicide Attempt

- [ ] Mother
- [ ] Father
- [ ] Grandmother
- [ ] Grandfather
- [ ] Sister
- [ ] Brother
- [x] Daughter
- [ ] Son
- [ ] Aunt
- [ ] Uncle
- [ ] Cousin

4. Family member:

Psychiatric Problem(s):

- [ ] Depression
- [ ] Social Anxiety Disorder
- [ ] Eating Disorder
- [ ] Obsessive Compulsive Disorder
- [ ] Panic Disorder
- [ ] Alcoholism
- [x] Generalized Anxiety Disorder
- [ ] Bipolar Disorder
- [ ] Drug Abuse
- [ ] Post Traumatic Stress Disorder
- [x] ADHD
- [ ] Personality Disorder
- [ ] Disruptive Behavior Problems
- [ ] Autism Spectrum Disorder
- [ ] Suicide
- [ ] Schizophrenia / Psychosis
- [ ] Suicide Attempt

- [ ] Mother
- [ ] Father
- [x] Grandmother
- [ ] Grandfather
- [x] Sister
- [ ] Brother
- [ ] Daughter
- [ ] Son
- [x] Aunt
- [ ] Uncle
- [ ] Cousin

5. Family member:

Psychiatric Problem(s):

- [x] Depression
- [ ] Obsessive Compulsive Disorder
- [x] Generalized Anxiety Disorder
- [ ] Post Traumatic Stress Disorder
- [ ] Disruptive Behavior Problems
- [x] Schizophrenia / Psychosis
- [ ] Social Anxiety Disorder
- [ ] Panic Disorder
- [ ] Bipolar Disorder
- [ ] ADHD
- [x] Autism Spectrum Disorder
- [x] Suicide Attempt
- [ ] Eating Disorder
- [ ] Alcoholism
- [ ] Drug Abuse
- [ ] Personality Disorder
- [ ] Suicide

Family Medical History

Is there any additional family medical history:

____

____

____

Developmental and Educational History

Instruction: If you are filling this out on behalf of the patient, please answer from the patient's perspective.

During your pregnancy/birth, did your mother have any problems with any of the following:

- [x] None of these
- [ ] Exposure to drugs or alcohol during pregnancy
- [ ] A difficult pregnancy
- [ ] Problems with delivery

Other: ____

Did you have any complications after your birth? (e.g. premature birth, jaundice, breathing difficulties)

- [ ] Yes
- [ ] No

Did you have any delays or difficulties in reaching the following developmental milestones?

- [ ] None of these
- [ ] Walking
- [x] Talking
- [ ] Toilet training
- [ ] Sleeping alone
- [x] Being away from parents
- [ ] Making friends

Other:

____

Which options below best describe your childhood home atmosphere?

- ☐ Normal
- ☒ Supportive
- ☒ Parental fighting
- ☐ Parental violence
- ☐ Financial difficulties
- ☐ Frequent moving

Other:

____

Which of the following challenges were experienced during your childhood?

- ☒ None of these
- ☐ Tantrums
- ☐ Enuresis (bed wetting)
- ☐ Encopresis (fecal incontinence)
- ☐ Running away from home
- ☒ Fighting
- ☐ Stealing
- ☐ Property damage
- ☐ Fire setting
- ☒ Animal cruelty
- ☒ Separation anxiety
- ☐ Victim of bullying
- ☐ Engaged in bullying
- ☐ Depression
- ☒ Death of a parent/caregiver
- ☒ Parental divorce

Which of the following best describe problems you may have had in school?

- ☐ None of these
- ☐ Fighting
- ☐ School phobia
- ☐ Truancy
- ☐ Detentions
- ☐ Suspensions
- ☐ Expulsions
- ☒ School refusal
- ☐ Class failures
- ☐ Repetition of grades
- ☐ Special education
- ☒ Remedial classes

Did you have additional schooling outside of the standard classroom setting? (please check all that apply)

- ☒ None of these
- ☐ Speech classes
- ☒ Tutoring
- ☐ Accommodations

Other:

____

Please select your highest Level of Education:

- ☒ Less than High School
- ☐ High School / GED
- ☒ Some college
- ☐ Two-year degree
- ☒ Four-year degree
- ☐ Graduate / Professional degree

Any further comments about your developmental or education and wish to elaborate:

____
__
____
____
____
____
______

General Social History

Instruction: If you are filling this out on behalf of the patient, please answer from the patient's perspective.

Which options below best describes your social situation?

- [ ] Supportive social network
- [x] Few friends
- [ ] Substance-use based friends
- [ ] No friends
- [x] Distant from family of origin
- [ ] Family conflict

Other: ______________________________

What is your current marital status?

- [ ] Single, never married
- [ ] Married / Permanent partnership
- [ ] Divorced
- [ ] Separated or divorce in process
- [ ] Widowed

What is the status of your intimate relationship?

- [ ] Never been in a serious relationship
- [ ] Not currently in a serious relationship
- [ ] Currently in a serious relationship

What is the satisfaction level of your intimate relationship?

- [ ] Very Satisfied
- [ ] Satisfied
- [ ] Somewhat satisfied
- [ ] Dissatisfied
- [ ] Not applicable

What is your sexual orientation?

- [ ] Heterosexual
- [ ] Homosexual
- [ ] Bisexual

What is your current living situation?
- ☐ Rent (apartment/house)
- ☐ Own (house/condo)
- ☐ Group home
- ☐ Homeless
- ☐ Foster care

Who do you currently live with? (Please check all that apply)
- ☐ Live alone
- ☐ Roommate(s)
- ☐ Partner/Spouse
- ☐ Parent(s)
- ☐ Sibling(s)
- ☐ Children

Other: ____

Do you currently participate in spiritual activities?
- ☐ Yes
- ☐ No

What is your current occupation status?
- ☐ Employed full-time
- ☐ Employed part-time
- ☐ Temporary/Seasonal employment
- ☐ Full-time student
- ☐ Part-time student
- ☐ Homemaker
- ☐ Unemployed (seeking work)
- ☐ Unemployed (not seeking work)
- ☐ Retired
- ☐ Disability

What is your current yearly income?
- ☐ Less than $11,000
- ☐ $11,000 - $25,999
- ☐ $26,000 - $75,999
- ☐ $76,000 - $100,000
- ☐ More than $100,000

What is your longest period of continuous employment? (Please include dates and description)

Employment start: _______ /________ /________

Employment end: _______ /________ /________

Description:

____

____

____

____

__

What is your longest period of continuous unemployment? (Please include dates and description)

Employment start: _______ /________ /________

Employment end: _______ /________ /________

Description:

____

____

____

____

__

Menstruation and Pregnancy History

Instruction: If you are filling this out on behalf of the patient, please answer from the patient's perspective.

At what age did you begin menstruation? ______

Which of these best describe your premenstrual symptoms? (Please check all that apply)

☐ None of these
☐ Dysphoria
☐ Cramps
☐ Appetite change
☐ Bloating
☐ Sleep disturbance

Do you have a method of contraception? (Please check all that apply)

- No method of contraception
- Intrauterine (e.g. IUD)
- Hormonal (e.g. implant, injection, “the pill,” patch, hormonal vaginal contraceptive ring)
- Barrier (e.g. diaphragm, male/female condom, spermicide)
- Fertility Awareness-based (e.g. natural family planning)
- Permanent (e.g. male/female sterilization, infertility)

Other: ____

Have you ever been pregnant?

- Yes
- No

If YES, how many times? _____

Have you ever given birth?

- Yes
- No

If YES, how many times? _____

Have you had any miscarriages?

- Yes
- No

If YES, how many times? _____

Have you had any abortions?

- Yes
- No

If YES, how many times? _____

Review of Systems

Please look at the list of physical symptoms below and check off any that you have experienced in the last several days. If you have NOT experienced any symptoms in an area, be sure to check “None of the above” for that area. *If you are filling this out on behalf of the patient, please answer from the patient’s perspective.*

Constitutional	**Eyes**	**Ears, Nose, Mouth, and Throat**
Chronic Pain	Eye pain	Earache
Loss of appetite	Eye discharge	Tinnitus (ringing in ears)
Increase in appetite	Eye redness	Decreased hearing or hearing loss
Unexplained weight loss	Blurred or double vision	Frequent ear infections

[x] Weight gain	[ ] Visual change	[ ] Frequent nose bleeds
[ ] Fatigue/Lethargy	[ ] History of eye surgery	[x] Sinus congestion
[x] Unexplained fever	[x] Sensitivity to light	[x] Runny nose/post-nasal drip
[ ] Hot or Cold spells	[ ] Scotomas (blind spots)	[x] Difficulty swallowing
[ ] Night sweats	[ ] Retinal hemorrhage (floaters in vision)	[ ] Frequent sore throat
[ ] Sleeping pattern disruption	[x] Amaurosis fugax (feeling like a curtain is pulled over vision)	[ ] Prolonged hoarseness
[x] Malaise (flu-like or vague sick feeling)		[x] Pain in jaw or tooth
		[ ] Dry mouth
[ ] Other:	[ ] Other:	[ ] Other:
[x] None of the above constitutional issues	[ ] None of the above eye issues	[x] None of the above ear, nose, mouth or throat issues

Cardiovascular	Respiratory	Musculoskeletal
[x] Chest pain	[ ] Pain with breathing	[x] Swelling of joints
[ ] Pacemaker	[x] Chronic cough	[ ] Redness of joints
[ ] Swollen feet or hands	[ ] Chronic shortness of breath	[x] Other joint pains or stiffness
[ ] Fainting spells	[x] Chronic wheezing/Asthma	[x] Muscle pain or cramping
[x] Shortness of breath with exercise	Excessive phlegm	[ ] Muscle weakness
Palpitations (fast or irregular heartbeat)	[ ] Nocturnal Dyspnea (shortness of breath at night)	Muscle stiffness
	[ ] Coughing blood	Decreased range of motion
		[ ] Back pain or stiffness
		[ ] History of fractures
		Past injury to spine or joints
Other:	[ ] Other:	[ ] Other:
[ ] None of the above cardiovascular issues	[ ] None of the above respiratory issues	None of the above musculoskeletal issues

Gastrointestinal

Excessive flatulence or belching	Heartburn	Change in appearance of stool
[ ] Diarrhea	[ ] Recent loss of appetite	[ ] Blood in stool
[ ] Constipation	Sensitivity to milk products	[ ] Dark/Tarry stool
[ ] Persistent nausea/vomiting	[ ] Jaundice (yellow skin)	[ ] Loss of bowl control/soiling
[ ] Abdominal Pain	Difficulty swallowing solids or liquids	

Other:

None of the above gastrointestinal issues

Allergic/Immunologic	Endocrine	Hematologic/Lymphatic
Frequent infections	Severe menopausal symptoms	Blood clots
Hives	Cold or heat intolerance	History of blood transfusion
Anaphylaxic reaction	Excessive appetite	Excessive bruising
	Excessive thirst or urination	Swollen glands (neck, armpit, groin)
	Excessive sweating	Excess/easy bleeding (surgery, dental work, brushing teeth, scrapes)
Other:	Other:	Other:
None of the above allergic or immunologic issues	None of the above endocrine issues	None of the above hematologic or Lymphatic issues

Genitourinary (General)	Genitourinary (Women)	Genitourinary (Men)
Loss of urine control (including bed-wetting)	Vaginal pain, bleeding, soreness, Or dryness	Slow urine stream
Painful/Burning urination	Unusual vaginal discharge	Scrotal pain
Blood in urine	Genital sores	Lump or mass in the testicles
Increased frequency of urination	Heavy or irregular periods	Abnormal penis discharge
Up more than twice/night to urinate	No menses (periods stopped)	Trouble getting/maintaining erections
Urine retention	Currently pregnant	Inability to ejaculate/orgasm
Frequent urine infections	Sterility/Infertility	Any other sexual or sex organ concerns
	Any other sexual or sex organ concerns	
Other:	Other:	Other:
None of the above genitourinary issues	None of the above sex-specific genitourinary issues	None of the above sex-specific genitourinary issues

Neurological	Integumentary (Skin/Breast and Hair)	Psychiatric
Paralysis	Lesions	In-depth review of psychiatric system appears earlier in document
Fainting spells or blackouts	Unusual mole	Feeling depressed
Dizziness/Vertigo	Easy bruising	Difficulty concentrating
Drowsiness	Increased perspiration	Phobias/Unexplained fears
Slurred speech	Rashes	No pleasure from life anymore
Speech problems (other)	Chronic dry skin	Anxiety

Neurological	Integumentary	Psychiatric
☑ Short term memory trouble	☐ Itchy skin or scalp	☑ Insomnia
☐ Memory difficulties (loss)	☐ Hair or nail changes	☐ Excessive moodiness
☐ Frequent headacheds	☐ Hair loss	☐ Stress
☐ Muscle weakness	☐ Breast tenderness	☐ Disturbing thoughts
☐ Numbness/Tingling sensations	Breast discharge	☐ Manic episodes
Neuropathy (numbness in feet)	☐ Breast lump or mass	☐ Confusion
☐ Tremor in hands/shaking		☐ Memory loss
Muscle spasms or tremors		☐ Nightmares
☐ Other:	☐ Other:	Other:
☐ None of the above neurological issues	None of the above integumentary issues	☐ None of the above psychiatric issues