

PERSONAL INFORMATION - Please fill out this form as completely as you can. Please *print* your answers.

Date		Gender	
Full Name		Ethnicity	
Birthdate		Marital Status	
Social Security Number		Occupation	

Contact Information - Please give your *home* address. Please circle the appropriate letter letting me know if I can leave a full message (M), call-back number only (C), or no message (N).

Address		Home Phone		M C N
City		Cell Phone		M C N
State		Work Phone		M C N
Zip		Email		M C N

Emergency Contact - Please tell me the name of someone to contact in an emergency.

Name		Relationship	
Address		Home Phone	
City		Cell Phone	
State		Work Phone	
Zip		Email	

Insurance Information - Please provide information requested below

	Primary	Secondary
Plan Name		
Subscriber		
Policy Number		
Group Number		
Phone		
Start/End Date		

Referral Source - Please tell me who suggested that you see me.

Name	
Phone	
Relationship to you	

Pharmacy - Please provide contact information for the primary pharmacy you use for your prescriptions.

Pharmacy Name/Location/
Phone

MEDICAL HISTORY

Medical Problems - Please list all major medical problems/injuries and treatments. Continues on next page. Continue on back if needed.

Medical Problem	When Diagnosed	Treatment(s)	When Treated
Medical Problem	When Diagnosed	Treatment(s)	When Treated

Surgeries - Please list all surgeries you have had, when and for what conditions. Continue on back if needed.

Operation	When Performed	Reason for Procedure

Current Medications and Supplements - Please list *all* medications and supplements (prescribed and over-the-counter) you take regularly. Continue on back if needed.

Medication or Supplement	Dose	Frequency	Reason You Take It

Allergies and Adverse Reactions - Please list any medications or foods to which you have had a bad reaction, including problems with anesthesia. Continue on back if needed.

Medication or Food	Reaction

Recent Symptoms and Tests - Please check any symptoms or tests you have had in the past year. Please indicate which body part was tested where applicable (X-ray of: chest, e.g.). Continues on next page. Continue on back if needed.

<input type="checkbox"/> Fatigue	<input type="checkbox"/> Swollen legs/feet	<input type="checkbox"/> Bloody/pink urine	<input type="checkbox"/> Memory problems
<input type="checkbox"/> Fever	<input type="checkbox"/> Pain on walking	<input type="checkbox"/> Cola-colored urine	<input type="checkbox"/> Coordination problems
<input type="checkbox"/> Weight loss OR gain	<input type="checkbox"/> Trouble/pain with swallowing	<input type="checkbox"/> Abnormal vaginal bleeding	<input type="checkbox"/> Seizures
<input type="checkbox"/> Night sweats	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Missed menstrual period(s)	<input type="checkbox"/> X-ray of:
<input type="checkbox"/> Enlarged lymph nodes	<input type="checkbox"/> Belly pain	<input type="checkbox"/> Vaginal OR penile discharge	
<input type="checkbox"/> Heat OR cold intolerance	<input type="checkbox"/> Bloating	<input type="checkbox"/> Anemia	<input type="checkbox"/> CT scan of:
<input type="checkbox"/> Increased urination	<input type="checkbox"/> Nausea/vomiting	<input type="checkbox"/> Easy bruising/bleeding	
<input type="checkbox"/> Increased thirst	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Rash/itching	<input type="checkbox"/> MRI of:
<input type="checkbox"/> Increased appetite	<input type="checkbox"/> Constipation	<input type="checkbox"/> Changes in moles	
<input type="checkbox"/> Hair loss	<input type="checkbox"/> Bowel habit change	<input type="checkbox"/> Lump/swelling of testicle	<input type="checkbox"/> Ultrasound scan of:
<input type="checkbox"/> Vision problems	<input type="checkbox"/> Blood in stool	<input type="checkbox"/> Breast lump/new discharge/skin change	
<input type="checkbox"/> Light hurts your eyes	<input type="checkbox"/> Black stool	<input type="checkbox"/> Joint/muscle pain	<input type="checkbox"/> EKG/stress test
<input type="checkbox"/> Hearing problems	<input type="checkbox"/> Clay-colored stool	<input type="checkbox"/> Limb weakness/numbness	<input type="checkbox"/> EEG
<input type="checkbox"/> Ear pain/discharge	<input type="checkbox"/> Loss of appetite	<input type="checkbox"/> Headaches	<input type="checkbox"/> Others:
<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Yellow skin/eyes	<input type="checkbox"/> Dizzy spells	
<input type="checkbox"/> Mouth sores	<input type="checkbox"/> Trouble urinating	<input type="checkbox"/> Fainting/loss of consciousness	

PSYCHIATRIC HISTORY

	Patient History		Family History		Specify Family Member (Mom, Dad, Sibling, etc.)
Depression	Y	N	Y	N	
Anxiety	Y	N	Y	N	
Bipolar Disorder	Y	N	Y	N	
Schizophrenia	Y	N	Y	N	
Suicide	Y	N	Y	N	
Other (Specify)					

PSYCHOSOCIAL RISK FACTORS

- Victim of Physical Abuse
- Victim of Sexual Abuse
- Trauma of Loss in Family
- Domestic Violence Victim Perpetrator
- History of Substance Abuse
- History of Assaultive Behavior
- History of Threatening Behavior
- History of Inappropriate Sexual Behavior
- Behavior influenced by Delusions or Hallucinations
- History of Self- Injury
- History of Suicidal Behavior
- Access to Firearms (family, friends, self)
- Access to Other Means of Suicide
- Lack of Social Support
- History of Foster Care
- Homelessness
- Other _____

SOCIAL HISTORY:

Marital Status: Married Partnered Single Divorced Widowed

Number of Children _____ Age of Children _____

Education _____ Current Occupation _____

Describe Any Legal Problems:

SUBSTANCE USE

- Cigarettes, Tobacco Products, Nicotine Chew etc. Frequency_____
- Coffee, Tea, Energy Drink, or Soda with Caffeine
- Alcohol Frequency_____
- Illegal or Street Drug Specify_____

Recent Psychiatric Symptoms - Please check any symptoms you have had during the past two weeks (or longer).

<input type="checkbox"/> Sad OR don't care	<input type="checkbox"/> Difficulty at work	<input type="checkbox"/> Cutting/hurting self	<input type="checkbox"/> Involuntary movements
<input type="checkbox"/> Trouble concentrating	<input type="checkbox"/> Interacting less	<input type="checkbox"/> Too much energy	<input type="checkbox"/> Hearing/seeing things
<input type="checkbox"/> Appetite increase OR decrease	<input type="checkbox"/> Can't make decisions	<input type="checkbox"/> Less need for sleep	<input type="checkbox"/> Need to count/check things
<input type="checkbox"/> Poor energy	<input type="checkbox"/> Don't enjoy things	<input type="checkbox"/> Impulsive/dangerous acts	<input type="checkbox"/> Generalized anxiety/panic attacks
<input type="checkbox"/> Poor motivation	<input type="checkbox"/> Not good at things	<input type="checkbox"/> Racing thoughts/talkative	<input type="checkbox"/> Afraid of/avoid things
<input type="checkbox"/> Trouble sleeping	<input type="checkbox"/> Guilt over bad deeds	<input type="checkbox"/> Lots of new plans	<input type="checkbox"/> Can't throw things away
<input type="checkbox"/> Sleeping too much	<input type="checkbox"/> Deserve punishment	<input type="checkbox"/> Don't trust people	<input type="checkbox"/> Binge eating
<input type="checkbox"/> Trouble getting started	<input type="checkbox"/> Worry about health	<input type="checkbox"/> Thoughts being inserted into your head	<input type="checkbox"/> Afraid to get fat
<input type="checkbox"/> Not getting out	<input type="checkbox"/> Worthless/hopeless	<input type="checkbox"/> Thoughts being blocked	<input type="checkbox"/> Starving self to control weight
<input type="checkbox"/> Irritability	<input type="checkbox"/> Life not worth living	<input type="checkbox"/> Thoughts being broadcast	<input type="checkbox"/> Vomiting/laxative use to control weight
<input type="checkbox"/> Interpersonal trouble	<input type="checkbox"/> Thoughts of suicide	<input type="checkbox"/> Getting messages from TV/radio	<input type="checkbox"/> Over-exercising to control weight