Patient History

1. Please enter your information.

Name: ______________________ Date of Birth: ______________

2. Please check yes or no for each of the following items:

	Yes	No
Are you often sad?		
Do you often feel hopeless?		
Do you have low energy?		
Are you losing interest in things you once found enjoyable?		
Do you have racing thoughts that keep you up for days?		
Do you have times where you feel your mood is on a “high" and you can’t calm down?		
Do you have times where your mood is on a “high” and you engage in reckless behavior (spending sprees, etc)?		
Do you ever have suicidal thoughts?		
Do you get angry often?		
Do you ever become violent?		
Do you eat excessively?		
Do you engage in binge eating?		
Do you undereat?		
Do you frequently restrict food to lose weight?		
Do you ever vomit after you eat?		
Do you have trouble falling asleep?		
Do you have trouble staying asleep?		
About how many hours of sleep do you get each night?		
Do you have any trouble breathing during the night?		
Do you worry excessively?		
Do you tend to worry most of the time?		
Do you feel nervous much of the time?		
Do you get easily distracted?		
Do you frequently require people to repeat things they have said to you?		
Do you tend to rush through things and make careless errors?		
Do you often lose things?		
Do you procrastinate to the point where people have to prod you to get things done?		
Are you frequently hyperactive?		
Do you talk excessively?		
Do you often interrupt others?		

3. Do you ever experience nervousness to the point of the following:

	Yes	No
Shaking		
Increased heart rate		
Shortness of breath		
Nausea		
Sweating		

4. If so, how long do the symptoms last? ______

How often do these episodes happen? ______

How long have you had these episodes? ______

5. Do you ever have flashbacks of upsetting events?

- Yes
- No

6. Do you frequently have nightmares?

- Yes
- No

7. Have you ever been exposed to an upsetting event which you feel affects your behavior?

- Yes
- No

8. If yes, please explain:

______
______
______
______

9. Do you ever hear things or voices that no one else does?

- Yes
- No

10. Do you ever see things that are not really there?

- Yes
- No

11. Do you drink alcohol?

- Yes
- No

12. If yes:

How often do you drink? ____________________

How much do you drink at one time? ____________________

13. Do you currently use illegal drugs?

- Yes
- No

14. If yes:

Which drugs? ____________________

How often? ____________________

15. Have you used illegal drugs in the past?

- Yes
- No

If yes, which drugs:

____

16. Do you drink caffeinated beverages?

- Yes
- No

17. If yes:

How much? ____________________

How often? ____________________

18. Have you ever taken psychiatric medications?

- Yes
- No

19. If yes, which medications:

	Medication Name	Dosage	Frequency
1			
2			
3			

20. Please list any current medical conditions:

____

____

____

____

21. Please list any past surgeries:

	Surgery	Date
1		
2		
3		

22. Please list current medications you are taking:

	Medication Name	Dosage	Frequency	Reason for Use
1				
2				
3				

23. Please list any allergies to medications:

	Drug Allergy	Reaction
1		
2		
3		

24. Is there any family history of psychiatric issues?

____

____

____

____

25. Who lives at home with you?

	Name	Relationship
1		
2		
3		

26. Do you work outside the home?

- Yes
- No

27. Are you in school?

- Yes
- No

28. Were there any problems with pregnancy or delivery?

29. Did you have colic as a baby?

- Yes
- No

30. Did you have any delays in sitting, walking, or talking?

- Yes
- No

31.

32.