Section I **Responsible Party**

Patient Name:_____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Guardian ☐ POA ☐ Other

SSN#:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone: (____)_____

Employer:_____ Work Phone: (____)_____

Section II **Insurance Information**

Name of Insured:_____DOB:_____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Guardian ☐ POA ☐ Other

SSN#:_____

Name of Employer:_____ Work Phone: (____)_____

Address of Employer:_____

City:_____State:_____Zip:_____

Insurance Company:_____

Group #:_____ ID#:_____

Ins. Co Address:_____

Ins. Co. Phone: (____)_____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ **Yes** ☐ **No**

IF **YES** COMPLETE THE FOLLOWING:

Name of Insured:_____DOB:_____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Guardian ☐ POA ☐ Other

SSN#_____

Name of Employer:_____ Work Phone: (____)_____

Address of Employer:_____

City:_____State:_____Zip:_____

Insurance Company:_____

Group #:_____ ID#:_____

Self-Assessment Form

Date Form Completed: _____

Full Legal Name: _____ Other Names Used: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone (circle best to use): Cell: _____ May we leave a message? ☐ Yes ☐No
Home: _____ May we leave a message? ☐ Yes ☐No
Work: _____ May we leave a message? ☐ Yes ☐No

Age: _____ Date of Birth: _____ Place of Birth: _____

Please list all people residing with you and their relationship: _____

_____

_____

Race (*circle all that apply*):

White, Black/African American, Hispanic or Latino, Asian, Pacific Islander, Alaska Native

Native American Tribe: _____ Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino

Religion/Spiritual Practice(s): _____

Education: _____ (Highest grade/ level completed) Degree, if any: _____

Occupation/How long: _____

Marital Status:

_____Never married
_____Married (how many times?)
_____Living cooperatively
_____Separated
_____Divorced (how many times?)
_____Widow/widower

Name of person to call in an emergency: _____

Relationship: _____

Phone Number to Call: Home/Cell/Work: _____

Address: _____

Name of Your Primary physician: _____

How did you learn about our office: _____

Name of person filling out this form, if not patient: _____

Please state the principal reason you are coming in for treatment: _____

Please describe your condition from when it started to the now: _____

Provide as many dates, names, of psychiatrists, psychologists, and/or social workers you have seen:

Please provide the dates and kinds of treatment for any psychiatric hospital stays you have received:

Please briefly describe any expectations you or your family members may have regarding treatment:

Suicide and Violence Risk (*please circle* "**yes**" or "**no**")

Have you ever thought about suicide? **Yes / No**

If "yes", when was the last time? _____

Have you ever attempted suicide? **Yes / No**

If "yes" when and how? _____

_____

_____

Do you have thoughts about suicide now? **Yes / No**

If "yes" do you have a plan? _____

_____

Do you have firearms within the home or within easy access? **Yes / No**

Have you ever been in a physical fight with anyone? **Yes / No**

If you are older than 25 years have you been in a physical fight since the age of 25? **Yes / No**

If yes, have you ever used a weapon (e.g. firearm, knife, baseball bat, broken bottle, etc.) in a fight? **Yes / No**

If yes, have you ever injured another person in a physical fight? **Yes / No**

If "yes" how? _____

_____

Recent stressful life events

(Check any of the following that have occurred in the past year) **Comments**

_____ engaged
_____ married
_____separated
_____divorced
_____breakup of important relationship
_____child left home
_____death of spouse or other loved one
_____bad health (behavior) of family member
_____personal injury, illness
_____changes at school, work
_____retired, lost job
_____changed residences
_____legal difficulties, multiple traffic tickets
_____owe money
_____traumatic experience(s)

Alcohol use (*please circle* "**yes**" or "**no**")

Do you currently drink Alcohol? **Yes / No** Did you use to drink Alcohol? **Yes / No**

If yes, how many drinks do you consume in an average day? _____ Week? _____

In the past 12 months, have you had 3 or more alcoholic drinks within a 3-hour period on 3 or more occasions? **Yes / No**

If "yes" please describe: _____

_____

_____

Was there ever a time when you felt you were, or someone told you, you were drinking too much? **Yes / No**
If "yes" under what circumstance? _____

Illicit Drug Abuse _____***never any***
Check any illicit drugs you **take or have** taken. List the circumstances and pattern of use, or any consequences to the use. Also state the amount you used at its heaviest, and the last time you used.

_____marijuana _____
_____amphetamine/speed _____
_____heroin/opiates/Oxycontin _____
_____PCP _____
_____LSD/hallucinogens _____
_____cocaine/crack _____
_____barbiturates/sedatives _____
_____other(s) (list) _____

Any treatment (hospital) or peer support group (AA, NA) for drug use? _____

Misuse of Prescriptive Drug _____***never any***
List any prescriptive medications that you have used other than as directed, the circumstances and pattern of use, or any consequences to the misuse of prescriptive medications: _____

Nicotine Use (cigarettes, vapor, dip, chew, pipe, cigar, etc.) _____***never any***
Do you use nicotine? **Yes / No**
If yes: what type(s); how much per day; and how long? _____

Have you tried or considered quitting nicotine? **Yes / No**
If yes describe how many times and what ways? _____

Caffeine
Do you drink caffeinated coffee, tea, or colas? **Yes / No**
If yes, how much per day? _____

Do you believe you are sensitive to caffeine? **Yes / No**

Develpmental History
Check if during childhood you- Comments

____were afraid to go to school/home schooled _____
____had difficulty with reading, writing, or math _____
____were truant or expelled _____
____failed/repeated or moved up a grade _____

____wet bed after age 5
____had tics
____had stutter/stammer
____had nightmares, poor sleep, fear of the dark
____ran away from home
____were cruel to animals
____frequently lied to families or others
____set fires
____moved frequently
____were exposed to incest
____worried excessively about your appearance
____were in special education

Any other concerns or developmental issues? **Yes / No**
If yes describe: _____

Family History (*List any depression, bipolar disorder, anxiety disorders, drug abuse, suicide attempts, etc.*)

	Name	Age	Conditions and Treatments
Mother			
Father			
Brothers			
Sisters			
Children			

Grandparents, aunts & uncles (relationship)

Health History

Weight

What is your current weight in pounds? _____ What is your height? _____

Has your weight increased or decreased by more than 10 pounds in the last year: **Yes / No**

If yes, please explain circumstances: _____

_____

_____

Have you ever had weight loss surgery? **Yes / No**

If yes, please describe: _____

_____

_____

Sleep

Have difficulty falling asleep?	**Yes / No**	Wake up short of breath?	**Yes / No**
Have difficulty staying asleep?	**Yes / No**	Wake up with a headache?	**Yes / No**
Are tired upon awakening?	**Yes / No**	Snore?	**Yes / No**
Have restless legs in your sleep?	**Yes / No**	Stop breathing when asleep?	**Yes / No**
Nap during your waking hours?	**Yes / No**	Fight/hit during your sleep?	**Yes / No**
Have you ever had a sleep study?	**Yes / No**	Feel rested after 4 or less hours?	**Yes / No**

How many hours, on average, do you sleep at night? _____

Sexual Functioning

Currently sexually active? **Yes / No**

Satisfied with libido or your level of desire? **Yes / No**

Satisfied with functioning? **Yes / No**

Allergies _____***no allergies***

List all medication and food allergies: _____

_____

_____

Medical Problems _____***no medical history/surgeries***

List all past and present medical problems as well as any surgeries or accidents. Please list the age of onset or occurrence: _____

_____

_____

_____

_____

_____

_____

_____

Have you had a/an/any (note when, why, results, etc.)

Yes / No Head injury: _____

Yes / No CAT Scan or MRI of the brain: _____

Yes / No Seizure(s): _____

Yes / No EEG: _____

Yes / No ECT / shock therapy: _____

Yes / No Neurological exam: _____

What do you consider to be some of your strengths and assets? _____

What do you consider to be some of your weaknesses? _____

Leisure/Recreational

Describe special areas of interest or hobbies (e.g., art, books, craft, physical fitness, sports, outdoor activities, church activities, walking, exercising, diet/health, hunting, fishing, bowling, traveling, etc.)

Activities	How often now?	How often in the past?

Current Medications (Include prescriptive, herbal and over-the-counter medications)

Name	**Dosage and frequency**	**Physician**	**How long**

Past Psychiatric Medications

Please review the following list of commonly prescribed psychotropic medications (both the trade name and generic name are provided when available in an effort to aid in your recall). Place a check mark in the box under any of the three categories if they apply to you and the medication you have taken in the past

Antidepressants

Check if *taken in past*	Check if *helpful*	Check if *side effects*	
☐	☐	☐	Anafranil / clomipramine
☐	☐	☐	Asendin / amoxapine
☐	☐	☐	Celexa / citalopram
☐	☐	☐	Cymbalta / duloxetine
☐	☐	☐	Desyrel / trazodone /
☐	☐	☐	Effexor / venlafaxine
☐	☐	☐	Elavil / amitriptyline
☐	☐	☐	Eldepryl / selegiline
☐	☐	☐	Emsam / selegiline
☐	☐	☐	Fetzima / levomilnacipran
☐	☐	☐	Lexapro / escitalopram
☐	☐	☐	Ludiomil / maprotiline
☐	☐	☐	Luvox / fluvoxamine
☐	☐	☐	Nardil / phenelzine
☐	☐	☐	Norpramin / desipramine
☐	☐	☐	Marplan / isocarboxazid
☐	☐	☐	Pamelor / nortriptyline / Aventyl
☐	☐	☐	Parnate / trancypromine
☐	☐	☐	Paxil / paroxetine
☐	☐	☐	Pristiq / desyenlafaxine
☐	☐	☐	Prozac / fluoxetine
☐	☐	☐	Remeron / mirtazepam
☐	☐	☐	Serzone / nefazodone
☐	☐	☐	Sinequan / doxepine / Silenor / Adapin
☐	☐	☐	Surmontil / trimipramine
☐	☐	☐	Symbyax / fluoxetine/olanzpaine
☐	☐	☐	Tofranil / imipramine
☐	☐	☐	Viibryd / vilazodone
☐	☐	☐	Wellbutrin / buproprion / Aplenzin
☐	☐	☐	Zoloft / sertraline
☐	☐	☐	Zyban / buproprion

Antipsychotic/Mood Stabilizers

Check if *taken in past*	Check if *helpful*	Check if *side effects*	
☐	☐	☐	Abilify / aripiprazole
☐	☐	☐	Clozaril / clozapine
☐	☐	☐	Fanapt / Iloperidone
☐	☐	☐	Geodon / ziprasidone
☐	☐	☐	Haldol / haloperidal
☐	☐	☐	Invega / paliperidone
☐	☐	☐	Latuda / lurasidone
☐	☐	☐	Loxitane / loxapine
☐	☐	☐	Mellaril / thioridazine
☐	☐	☐	Moban / molindone
☐	☐	☐	Navane / thiothixene
☐	☐	☐	Orap / pimozide
☐	☐	☐	Prolixin / fluphenazine
☐	☐	☐	Risperdal / risperidone
☐	☐	☐	Saphris / asenapine
☐	☐	☐	Seroquel / quetiapine
☐	☐	☐	Stelazine / trifluoperazine
☐	☐	☐	Thorazine / chlorpromazine
☐	☐	☐	Trilafon / perphenazine
☐	☐	☐	Vraylar / cariprazine
☐	☐	☐	Zyprexa / olanzapine

Mood Stabilizers

☐	☐	☐	Depakene / valproic acid
☐	☐	☐	Depakote / divalproex
☐	☐	☐	Eskalith / Lithobid / lithium
☐	☐	☐	Keppra / levetiracetam
☐	☐	☐	Lamictal / lamotrigine
☐	☐	☐	Tegretol / Carbatrol / carbamazepine
☐	☐	☐	Topamax / topiramate
☐	☐	☐	Trileptal / oxcarbazepine

Check if *taken in past*	Check if *helpful*	Check if *side effects*	
			Sedative/Hypnotics
☐	☐	☐	Ambien / zolpidem
☐	☐	☐	Dalmane / flurazepam
☐	☐	☐	Halcion / triazolam
☐	☐	☐	Lunesta / eszopiclone
☐	☐	☐	Placidyl / ethchlorvynol
☐	☐	☐	Prosom / estazolam
☐	☐	☐	Restoril / temazepam
☐	☐	☐	Rozerem / ramelteon
☐	☐	☐	Somnote / chloral hydrate
☐	☐	☐	Sonata / zaleplon
			Alzheimer/Dementia
☐	☐	☐	Aricept / donepezil
☐	☐	☐	Exelon / rivastigmine
☐	☐	☐	Namenda / memantine
☐	☐	☐	Namzaric / memantine & donepezil
☐	☐	☐	Reminyl / Razadyne / galantamine
			ADHD/Stimulants
☐	☐	☐	Adderall / Adderall XR
☐	☐	☐	Cylert / pemoline
☐	☐	☐	Dexedrine/ Dextrostat / dextroamphetamine
☐	☐	☐	Focalin / Focalin XR / dexmethylphenidate
☐	☐	☐	Intuniv / guanfacine
☐	☐	☐	Nuvigil / armodafinil
☐	☐	☐	Provigil / modafinil
☐	☐	☐	Ritalin / Concerta / Methylin / methylphenidate
☐	☐	☐	Strattera / atomoxetine
☐	☐	☐	Vyvanse / lisdexamfetamine

Check if *taken in past*	Check if *helpful*	Check if *side effects*	
			Non-benzodiazepine Anxiolytics
☐	☐	☐	Atarax / Vistaril / hydroxyzine
☐	☐	☐	Buspar / buspirone
☐	☐	☐	Catapres / clonidine
☐	☐	☐	Equanil / Miltown / meprobamate
☐	☐	☐	Gabitril / tiagabine
☐	☐	☐	Inderal / propranolol
☐	☐	☐	Neurontin / gabapentin
			Anxiolytics
☐	☐	☐	Ativan / lorazepam
☐	☐	☐	Klonopin / clonazepam
☐	☐	☐	Librium / chlordiazepoxide
☐	☐	☐	Serax / oxazepam
☐	☐	☐	Tranxene / clorazepate
☐	☐	☐	Valium / diazepam
☐	☐	☐	Xanax / alprazolam
			Other
☐	☐	☐	Chantix / varenicline
☐	☐	☐	Nuedexta
☐	☐	☐	Austedo / deutetrabenazine
☐	☐	☐	Ingrezza / valbenazine
			Procedures
☐	☐	☐	Ketamine Infusion
☐	☐	☐	Spravato / esketamine
☐	☐	☐	ECT / Electroconvulsive therapy
☐	☐	☐	TMS / Transcranial magnetic stimulation

REVIEW OF SYSTEMS- Please review the following items carefully.
Please circle P for PAST OR N for NOW

CONSTITUTIONAL
P N Chills
P N Daytime drowsiness
P N Fatigue
P N Fever
P N Night sweats
P N Weight gain
P N Weight loss

EYES
P N Wear glasses/contact lenses
P N Blindness
P N Cataracts
P N Glaucoma
P N
Other:_____

EARS / NOSE / THROAT
P N Difficulty/Loss of hearing
P N Ringing in the ears
P N Frequent ear aches
P N Discharge from the ear
P N Dizziness
P N Sinus trouble
P N Nasal blockage
P N Frequent sneezing
P N Frequent sore throat
P N Snoring
P N Recent change in voice
P N Sleep apnea
P N Difficulty in swallowing
P N Nose bleeds
P N
Other:_____

HEART & CIRCULATION
P N Heart attack
P N High blood pressure
P N Heart murmur
P N Chest pain (angina)
P N Heart failure
P N Racing/pounding heart
P N Shortness of breath
P N Stroke, TIA (mini stroke)
P N Blood clot in artery or vein
P N Black out spells
P N Aneurysm
P N Swelling of legs
P N Heart palpitations
P N
Other:_____

RESPIRATORY
P N Asthma or wheezing
P N Recent bronchitis or chest cold
P N Cough
P N Coughing up blood
P N Shortness of breath

BLOOD
P N Easy bleeding or bruising
P N Previous blood transfusion
P N Other:_____

STOMACH / INTESTINES
P N Ulcer
P N Heartburn or indigestion
P N Hiatal hernia
P N Poor appetite
P N Gall bladder attacks
P N Frequent diarrhea
P N Chronic constipation
P N Bloody stools
P N Abnormal stools
P N Liver disease or jaundice
P N Other:_____

KIDNEYS / URINARY TRACT
P N Kidney disease or failure
P N Kidney dialysis
P N Kidney stones or infection
P N Pain/burning with urination
P N Trouble starting urination
P N Dribbling or incontinence
P N Frequent urination
P N Bladder infection(s)
P N Blood in urine
P N Other:_____

MUSCLES / BONES / JOINTS
P N Arthritis
P N Back pain
P N Other:_____

ALLERGY
P N Food intolerance
P N Itching
P N Nasal congestion
P N Rash
P N Sneezing
P N Other:_____

SKIN
P N Rash
P N Psoriasis
P N Dermatitis
P N Skin cancer
P N Skin growth
P N Other:_____

ENDOCRINE / METABOLISM
P N Thyroid disorder
P N Unusual hair loss or growth
P N Goiter (enlarged thyroid)
P N Diabetes
P N Other:_____

NERVOUS SYSTEM
P N Behavioral change
P N Confusion
P N Memory loss
P N Headache
P N Closed head injury
P N Open head injury

P N Epilepsy or seizures
Date of last seizure:_____

P N Other:_____

MEN ONLY
P N Testicular swelling
P N Prostate Problems
P N Other:_____

WOMEN ONLY
P N Painful periods
P N Excessive Flow
P N Irregular cycles
P N Vaginal Burning
P N Hot Flash
P N Other:_____

Yes No I am pregnant
Yes No I am planning on becoming pregnant
Yes No I am using birth control
Specify type:_____