

Date:

Pt. Initials:

DOB:

Allergies:

Clinical History Form

Primary reason you are seeking care? (Can't sleep, anxiety, depression, mood swings, etc.):

How would YOU rate the overall severity level of the concern you listed above? (select one):

Mild

Moderate

Severe

What does it make you feel like on the inside? (On-edge, fatigued, empty, no pleasure from life anymore, scatterbrained, sad, hopeless, jittery, on high-alert, helpless, etc.):

When did it start? (Elementary school, middle school, college, after starting a family, after using illicit drugs, etc.):

Is it constant/persistent? Or does it come and go depending on your stressors/situation?

Was there any significant incident/stressor, that you can recall, happened around the time (within six months of the incident) you FIRST noticed the symptoms? (Parental divorce, loss of someone you were very close to, starting college or a new job, natural disaster, homelessness, abuse, being bullied, combat exposure, etc.):

What seems to trigger it now? (Stress, lack of sleep, too much caffeine, family, big crowds, substance abuse, etc.):

Does anything make it better? (Adequate sleep, exercise, eating better, listening to music, reading, watching T.V., attending therapy, medications, etc.):

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
<i>Add the score for each column</i>	+	+	+	
Total Score (add your column scores) =				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____

Somewhat difficult _____

Very difficult _____

Extremely difficult _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Intern Med.* 2006;166:1092-1097.

PCL-5

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

In the past month, how much were you bothered by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were happening again (as if you were actually back there reliving it)?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4

14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being "superalert" or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

NIDA- Modified ASSIST

1.

In your <u>LIFETIME</u> , which of the following substances have you ever used?	YES	NO
a. Cannabis (marijuana, pot, grass, hash, ect.)		
b. Cocaine (coke, crack, ect.)		
c. Prescription stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, ect.)		
d. Methamphetamine (speed, crystal meth, ice, ect.)		
e. Inhalants (nitrous oxide, glue, gas, paint thinner, ect.)		
f. Sedatives or sleeping pills (Valium, Serepax, Ativan, Xanax, Librium, Rohypnol, GHB, ect.)		
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K)		
h. Street opioids (heroin, opium, ect.)		
i. Prescription opioids (fentanyl, oxycodone, [Oxycontin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, ect.)		
j. Other- Specify		

2.

<u>In the past three months</u> , how often have you used the substances you mentioned (first drug, second drug, ect.)?	Never	Once or Twice	Monthly	Weekly	Daily or almost daily
a. Cannabis (marijuana, pot, grass, hash, ect.)	0	2	3	4	6
b. Cocaine (coke, crack, ect.)	0	2	3	4	6
c. Prescription stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, ect.)	0	2	3	4	6
d. Methamphetamine (speed, crystal meth, ice, ect.)	0	2	3	4	6
e. Inhalants (nitrous oxide, glue, gas, paint thinner, ect.)	0	2	3	4	6
f. Sedatives or sleeping pills (Valium, Serepax, Ativan, Xanax, Librium, Rohypnol, GHB, ect.)	0	2	3	4	6

g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K)	0	2	3	4	6
h. Street opioids (heroin, opium, ect.)	0	2	3	4	6
i. Prescription opioids (fentanyl, oxycodone, [Oxycontin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, ect.)	0	2	3	4	6
j. Other- Specify	0	2	3	4	6

3.

In the past three months, how often have you had a strong desire or urge to use (first drug, second drug, ect)	Never	Once or Twice	Monthly	Weekly	Daily or almost daily
a. Cannabis (marijuana, pot, grass, hash, ect.)	0	3	4	5	6
b. Cocaine (coke, crack, ect.)	0	3	4	5	6
c. Prescription stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, ect.)	0	3	4	5	6
d. Methamphetamine (speed, crystal meth, ice, ect.)	0	3	4	5	6
e. Inhalants (nitrous oxide, glue, gas, paint thinner, ect.)	0	3	4	5	6
f. Sedatives or sleeping pills (Valium, Serepax, Ativan, Xanax, Librium, Rohypnol, GHB, ect.)	0	3	4	5	6
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K)	0	3	4	5	6
h. Street opioids (heroin, opium, ect.)	0	3	4	5	6
i. Prescription opioids (fentanyl, oxycodone, [Oxycontin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, ect.)	0	3	4	5	6
j. Other- Specify	0	3	4	5	6

c. Prescription stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, ect.)	0	5	6	7	8
d. Methamphetamine (speed, crystal meth, ice, ect.)	0	5	6	7	8
e. Inhalants (nitrous oxide, glue, gas, paint thinner, ect.)	0	5	6	7	8
f. Sedatives or sleeping pills (Valium, Serepax, Ativan, Xanax, Librium, Rohypnol, GHB, ect.)	0	5	6	7	8
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K)	0	5	6	7	8
h. Street opioids (heroin, opium, ect.)	0	5	6	7	8
i. Prescription opioids (fentanyl, oxycodone, [Oxycontin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, ect.)	0	5	6	7	8
j. Other- Specify	0	5	6	7	8

6.

Has a friend or relative or anyone else <u>ever</u> expressed concern about your use of (first drug, second drug, ect)?	No, never	Yes, but not in the past 3 months	Yes, in the past 3 months
a. Cannabis (marijuana, pot, grass, hash, ect.)	0	3	6
b. Cocaine (coke, crack, ect.)	0	3	6
c. Prescription stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, ect.)	0	3	6
d. Methamphetamine (speed, crystal meth, ice, ect.)	0	3	6
e. Inhalants (nitrous oxide, glue, gas, paint thinner, ect.)	0	3	6
f. Sedatives or sleeping pills (Valium, Serepax, Ativan, Xanax, Librium, Rohypnol, GHB, ect.)	0	3	6
g. Hallucinogens (LSD, acid, mushrooms, PCP,	0	3	6

Special K)			
h. Street opioids (heroin, opium, ect.)	0	3	6
i. Prescription opioids (fentanyl, oxycodone, [Oxycontin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, ect.)	0	3	6
j. Other- Specify	0	3	6

7.

Have you ever tried and failed to control, cut down, or stop using (first drug, second drug, ect)?	No, never	Yes, but not in the past 3 months	Yes, in the past 3 months
a. Cannabis (marijuana, pot, grass, hash, ect.)	0	3	6
b. Cocaine (coke, crack, ect.)	0	3	6
c. Prescription stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, ect.)	0	3	6
d. Methamphetamine (speed, crystal meth, ice, ect.)	0	3	6
e. Inhalants (nitrous oxide, glue, gas, paint thinner, ect.)	0	3	6
f. Sedatives or sleeping pills (Valium, Serepax, Ativan, Xanax, Librium, Rohypnol, GHB, ect.)	0	3	6
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K)	0	3	6
h. Street opioids (heroin, opium, ect.)	0	3	6
i. Prescription opioids (fentanyl, oxycodone, [Oxycontin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, ect.)	0	3	6
j. Other- Specify	0	3	6

8. Have you ever used any drug by injection (NONMEDICAL USE ONLY)?

- No, never
- Yes, but not within the past three months
- Yes, within the last three months.

➤ Date of last use: _____

	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory. (e.g., learning new information) or with location(e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	

	24. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
	25. Problems with memory. (e.g., learning new information) or with location(e.g., finding your way home)?	0	1	2	3	4	
	26. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	27. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	

Recovery Assessment Scale 24 -item (RAS-R)

INSTRUCTIONS: Below is a list of statements that describe how people sometimes feel about themselves and their lives. Please read each one carefully and indicate the number (1-5) that best describes the extent to which you agree or disagree with the statement. Provide only one number for each statement and do not skip any items.

Item Response options: 1 = strongly disagree; 2 = disagree; 3 = not sure; 4 = agree; 5 = strongly agree

1. I have a desire to succeed
2. I have my own plan for how to stay or become well
3. I have goals in life that I want to reach
4. I believe that I can meet my current personal goals
5. I have a purpose in life
6. Even when I don't care about myself, other people do
7. Fear doesn't stop me from living the way I want to
8. I can handle what happens in my life
9. I like myself
10. If people really knew me, they would like me
11. I have an idea of who I want to become
12. Something good will eventually happen
13. I'm hopeful about my future
14. I continue to have new interests
15. Coping with my mental illness is no longer the main focus of my life
16. My symptoms interfere less and less with my life
17. My symptoms seem to be a problem for shorter periods of time each time they occur
18. I know when to ask for help
19. I am willing to ask for help
20. I ask for help when I need it
21. I can handle stress
22. I have people I can count on
23. Even when I don't believe in myself, other people do
24. It is important to have a variety of friends



In the past <u>30 days</u> , how much <u>difficulty</u> did you have in:						
Self-care						
D3.1	<u>Washing your whole body?</u>	None	Mild	Moderate	Severe	Extreme or cannot do
D3.2	<u>Getting dressed?</u>	None	Mild	Moderate	Severe	Extreme or cannot do
D3.3	<u>Eating?</u>	None	Mild	Moderate	Severe	Extreme or cannot do
D3.4	Staying <u>by yourself</u> for a <u>few days</u> ?	None	Mild	Moderate	Severe	Extreme or cannot do
Getting along with people						
D4.1	<u>Dealing</u> with people <u>you do not know</u> ?	None	Mild	Moderate	Severe	Extreme or cannot do
D4.2	<u>Maintaining a friendship?</u>	None	Mild	Moderate	Severe	Extreme or cannot do
D4.3	<u>Getting along</u> with people who are <u>close</u> to you?	None	Mild	Moderate	Severe	Extreme or cannot do
D4.4	<u>Making new friends?</u>	None	Mild	Moderate	Severe	Extreme or cannot do
D4.5	<u>Sexual activities?</u>	None	Mild	Moderate	Severe	Extreme or cannot do
Life activities						
D5.1	Taking care of your <u>household responsibilities</u> ?	None	Mild	Moderate	Severe	Extreme or cannot do
D5.2	Doing most important household tasks <u>well</u> ?	None	Mild	Moderate	Severe	Extreme or cannot do
D5.3	Getting all the household work <u>done</u> that you needed to do?	None	Mild	Moderate	Severe	Extreme or cannot do
D5.4	Getting your household work done as <u>quickly</u> as needed?	None	Mild	Moderate	Severe	Extreme or cannot do

Please continue to next page ...

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 section.

Constitutional	Eyes	Ears, Nose, Mouth, and Throat
<input type="radio"/> Chronic Pain	<input type="radio"/> Eye Pain	<input type="radio"/> Earache
<input type="radio"/> Loss of appetite	<input type="radio"/> Eye discharge	<input type="radio"/> Tinnitus (Ringing in the ear)
<input type="radio"/> Increased appetite	<input type="radio"/> Eye Redness	<input type="radio"/> Decreased hearing or hearing loss
<input type="radio"/> Unexplained weight loss	<input type="radio"/> Blurred or double vision	<input type="radio"/> Frequent ear infections
<input type="radio"/> Weight gain	<input type="radio"/> Visual changes	<input type="radio"/> Frequent nose bleeds
<input type="radio"/> Fatigue/Lethargy	<input type="radio"/> History of eye surgery	<input type="radio"/> Sinus congestion
<input type="radio"/> Unexplained fever	<input type="radio"/> Sensitivity to light	<input type="radio"/> Runny nose/post-nasal drip
<input type="radio"/> Hot or cold spells	<input type="radio"/> Scotomas (Blind spots)	<input type="radio"/> Difficulty swallowing
<input type="radio"/> Night sweats	<input type="radio"/> Retinal hemorrhage	<input type="radio"/> Frequent sore throat
<input type="radio"/> Sleeping pattern disruption	<input type="radio"/> Amaurosis fugax (feeling like a curtain is pulled over vision)	<input type="radio"/> Prolonged hoarseness
<input type="radio"/> Malaise		<input type="radio"/> Pain in jaw or tooth
		<input type="radio"/> Dry mouth
<input type="radio"/> Other:	<input type="radio"/> Other:	<input type="radio"/> Other:
<input type="radio"/> None of the above constitutional issues	<input type="radio"/> None of the above eye issues	<input type="radio"/> None of the above Ears, Nose, Mouth, and Throat issues
Cardiovascular	Respiratory	Musculoskeletal
<input type="radio"/> Chest pain	<input type="radio"/> Pain with breathing	<input type="radio"/> Swelling in joints
<input type="radio"/> Pace maker	<input type="radio"/> Chronic cough	<input type="radio"/> Redness of joints
<input type="radio"/> Palpitations (fast or irregular heartbeat)	<input type="radio"/> Chronic shortness of breath	<input type="radio"/> Other joint pains or stiffness
<input type="radio"/> Swollen feet or hands	<input type="radio"/> Chronic wheezing or asthma	<input type="radio"/> Muscle pain or cramping
<input type="radio"/> Fainting spells	<input type="radio"/> Excessive phlegm	<input type="radio"/> Muscle weakness

	<input type="radio"/> Coughing up blood	<input type="radio"/> Muscle stiffness
		<input type="radio"/> Decreased range of motion
		<input type="radio"/> Back pain or stiffness
		<input type="radio"/> History of fractures
		<input type="radio"/> Past injury to spine or joints
<input type="radio"/> Other: _____	<input type="radio"/> Other: _____	<input type="radio"/> Other: _____
<input type="radio"/> None of the above cardiovascular issues	<input type="radio"/> None of the above respiratory issues	<input type="radio"/> None of the above musculoskeletal issues
Gastrointestinal		
<input type="radio"/> Excessive gas or belching	<input type="radio"/> Heartburn	<input type="radio"/> Change in appearance of stool
<input type="radio"/> Diarrhea	<input type="radio"/> Difficulty swallowing solids or liquids	<input type="radio"/> Blood in stool
<input type="radio"/> Constipation	<input type="radio"/> Recent loss in appetite	<input type="radio"/> Dark/tarry stool
<input type="radio"/> Persistent nausea/vomiting	<input type="radio"/> Sensitivity to milk products	<input type="radio"/> Loss of bowel control/soiling
<input type="radio"/> Abdominal pain	<input type="radio"/> Jaundice (yellow skin)	
<input type="radio"/> Other: _____		<input type="radio"/> None of the above gastrointestinal issues
Allergic/Immunologic	Endocrine	Hematologic/Lymphatic
<input type="radio"/> Frequent infections	<input type="radio"/> Severe menopausal symptoms	<input type="radio"/> Blood clots
<input type="radio"/> Hives	<input type="radio"/> Cold or heat intolerance	<input type="radio"/> Excess/easy bleeding (surgery, dental work, brushing teeth, scrapes)
<input type="radio"/> Anaphylactic reaction	<input type="radio"/> Excessive appetite	<input type="radio"/> History of blood transfusion
		<input type="radio"/> Excessive bruising
		<input type="radio"/> Swollen glands (neck, armpits, groin)
<input type="radio"/> Other: _____	<input type="radio"/> Other: _____	<input type="radio"/> Other: _____
<input type="radio"/> None of the above allergic/immunologic issues	<input type="radio"/> None of the above allergic/immunologic issues	<input type="radio"/> None of the above allergic/immunologic issues
Genitourinary (General)	Genitourinary (Women)	Genitourinary (Men)
Loss of urine control	Unusual vaginal discharge	Slow urine stream

○ Painful/burning urination	○ Vaginal pain, bleeding, soreness, or dryness	○ 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 per 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 general 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 (to be checked by clinician only)
○ 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
○ Short term memory trouble	○ Itchy skin or scalp	○ Insomnia
○ Memory loss	○ Hair or nail changes	○ Excessive moodiness
○ Frequent headaches	○ 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: _____

<input type="radio"/> None of the above neurological issues	<input type="radio"/> None of the above integumentary issues	<input type="radio"/> None of the above psychiatric issues
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Stressors

Please rate the severity of stress you are experiencing related to each of the following categories.

	None	Mild	Moderate	Severe
Family				
Friends				
Relationships				
Educational				
Economic/Financial				
Occupational				
Housing				
Legal				
Health				

Substance Abuse Treatment History

Treatment Type	Yes	No	How many episodes of treatment?	Age at time of first treatment	Age at time of last treatment	Any additional information
Inpatient						
Intensive Outpatient						
Outpatient						
12-step Program						
Other						
Other						

Consequences of Substance Abuse

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

- 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
- Increased tolerance
- Withdrawal (shakes, sweating, nausea, rapid heart rate)
- Seizures
- Blackouts
- Effects on physical health
- Using/consuming more than intended
- Unintentional overdose
- DUI
- Arrests
- Physical fights or assaults
- Relationship conflicts
- Problems with money
- Job loss or problems at work/school
- Other (Please specify):

Inpatient Psychiatric History

Do you have a history of inpatient psychiatric treatment?

- Yes
- No

Please list any past inpatient treatment history below. Start with most recent and list each episode of treatment as a separate line. For the “Treatment Outcome” please list whether the outcome was feeling worse or negative result, minor improvement or no effect, partial response, significant improvement, resolved or nearly resolved your problem.

Hospital/ Facility	Was it voluntary? Yes/No	Primary reason for hospitalization.	How old were you?	Treatment Outcome	Additional Comments

Outpatient Psychiatric History

Do you have a history of outpatient psychiatric treatment?

- Yes
- No

Please list any past outpatient treatment history below. Start with most recent and list each episode of treatment as a separate line. For the “Treatment Outcome” please list whether the outcome was feeling worse or negative result, minor improvement or no effect, partial response, significant improvement, resolved or nearly resolved your problem.

Provider	Primary reason for seeking treatment	Age of first treatment	Age of last treatment	Treatment Outcome	Additional Comments

Suicide/Self-Harm History

Have you ever tried to harm or kill yourself?

- Yes
- No

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

Was your intent to die?

- Yes
- No

How many times in your life has this occurred? _____

Please describe your **most severe** episode.

Date: _____

Method: _____

Consequences: _____

Please describe your **most recent** episode.

Date: _____

Method: _____

Consequences: _____

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

- allergies
- anemia
- arthritis
- asthma
- back problems
- cancer
- cataracts
- chickenpox
- chronic bronchitis
- COPD
- Diabetes
- Diverticulitis
- fainting spells/
passing out
- fibromyalgia
- high cholesterol
- gall bladder disease
- gastritis/ulcer
- glaucoma
- gout
- hearing loss
- heart disease
- heart defect from
birth
- heart valve
problems
- hemorrhoids
- hepatitis
- hernia
- HIV
- Hypertension
- Hypotension
- IBS
- iron deficiency
- kidney disease
- kidney stones
- liver disease
- lupus
- migraine headaches
- multiple sclerosis
- obesity
- Parkinson's Disease
- Polyps
- Seizures
- sexually
transmitted disease
- sleep apnea
- stroke/TIA
- low testosterone
- thyroid problems
- tuberculosis or
exposure to
tuberculosis

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

- back/neck brain
- cardiac
- ear/nose/throat
- gall bladder
- hernia
- hip/knee/ankle/foot
- hysterectomy
(ovaries removed)
- hysterectomy
(ovaries retained)
- intestine
- kidney
- liver
- lung
- pancreas
- pelvis
- penis
- prostate
- gender affirming
surgery
- shoulder/elbow/
wrist/hand
- stomach
- tonsils
- vagina
- weight loss

Psychiatric Medication History

Place a circle any medication you recall ever being on in the past, but are not currently prescribed.

Antidepressants

amitriptyline (Elavil®)	imipramine (Tofranil®)	vortioxetine (Trintellix®)
bupropion (Wellbutrin®)	levomilnacipran (Fetzima®)	citalopram (Celexa®)
clomipramine (Anafranil®)	nortriptyline (Pamelor®)	escitalopram (Lexapro®)
desipramine (Norpramin®)	selegiline (Emsam®)	paroxetine (Paxil®)
desvenlafaxine (Pristiq®)	trazodone (Desyrel®)	sertraline (Zoloft®)
doxepin (Sinequan®)	venlafaxine (Effexor®)	mirtazapine (Remeron®)
fluoxetine (Prozac®)	vilazodone (Viibryd®)	duloxetine (Cymbalta®)
		fluvoxamine (Luvox®)

Anxiolytics and Hypnotics

alprazolam (Xanax®)	suvorexant (Belsomra®)	clorazepate (Tranxene®)
bupirone (BuSpar®)	temazepam (Restoril®)	diazepam (Valium®)
clonazepam (Klonopin®)	zolpidem (Ambien®)	lorazepam (Ativan®)
eszopiclone (Lunesta®)	chlordiazepoxide (Librium®)	oxazepam (Serax®)
lemborexant (Dayvigo®)		propranolol (Inderal®)

Antipsychotics

aripiprazole (Abilify®)	paliperidone (Invega®)	chlorpromazine (Thorazine®)
brexpiprazole (Rexulti®)	perphenazine (Trilafon®)	haloperidol (Haldol®)
cariprazine (Vraylar®)	quetiapine (Seroquel®)	thioridazine (Mellaril®)
fluphenazine (Prolixin®)	risperidone (Risperdal®)	clozapine (Clozaril®)
iloperidone (Fanapt®)	ziprasidone (Geodon®)	olanzapine (Zyprexa®)
lumateperone (Caplyta®)	asenapine (Saphris®)	thiothixene (Navane®)
lurasidone (Latuda®)		

Mood Stabilizers

carbamazepine
(Tegretol®)

lamotrigine (Lamictal®)

oxcarbazepine (Trileptal®)

valproic acid/divalproex
(Depakote®)

gabapentin (Neurontin®)

lithium (Eskalith®)

topiramate (Topamax®)

Stimulants/Non-Stimulants

Dexmethylphenidate
(Focalin®)

methylphenidate (Ritalin®,
Concerta®)

amphetamine salts
(Adderall®)

dextroamphetamine
(Dexedrine®)

lisdexamfetamine
(Vyvanse®)

atomoxetine (Strattera®)

guanfacine (Intuniv®)

viloxazine (Qelbree®)

clonidine (Kapvay®)

Any medication not listed above:

Family History

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

- Yes
- No

If yes, please elaborate below.

Mom: _____

Dad: _____

Sisters: _____

Brothers: _____

Aunts: _____

Uncles: _____

Paternal Grandparents: _____

Maternal Grandparents: _____

Family Medical History

Do you have any family members with a history of medical illness? (Diabetes, High blood pressure, High Cholesterol, Heart Disease, Stroke, Hyper/Hypothyroidism, Anemia, Cancer, etc.).

- Yes
- No

If yes, please elaborate below.

Mom: _____

Dad: _____

Sisters: _____

Brothers: _____

Aunts: _____

Uncles: _____

Paternal Grandparents: _____

Maternal Grandparents: _____

Developmental and Educational History

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

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

- Walking
- Talking
- Toilet training

- Sleeping alone
- Being away from parents
- Making friends
- None of these
- 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?

- | | |
|---|---|
| <input type="radio"/> Tantrums | <input type="radio"/> Animal cruelty |
| <input type="radio"/> Enuresis (bed wetting) | <input type="radio"/> Separation anxiety |
| <input type="radio"/> Encopresis (fecal incontinence) | <input type="radio"/> Victim of bullying |
| <input type="radio"/> Running away from home | <input type="radio"/> Engaged in bullying |
| <input type="radio"/> Fighting | <input type="radio"/> Depression |
| <input type="radio"/> Stealing | <input type="radio"/> Death of a parent/caregiver |
| <input type="radio"/> Property damage | <input type="radio"/> Parental divorce |
| <input type="radio"/> Fire setting | <input type="radio"/> None of these |

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

- | | |
|-------------------------------------|--|
| <input type="radio"/> Fighting | <input type="radio"/> School refusal |
| <input type="radio"/> School phobia | <input type="radio"/> Class failures |
| <input type="radio"/> Truancy | <input type="radio"/> Repetition of grades |
| <input type="radio"/> Detentions | <input type="radio"/> Special Education |
| <input type="radio"/> Suspensions | <input type="radio"/> Remedial Classes |
| <input type="radio"/> Expulsions | |

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

- Tutoring
- Accommodations
- Other: _____
- None of these
- Speech classes

What is your highest level of education?

- Less than high school diploma
- High school diploma or equivalency
- Some College
- Two year degree
- Four year degree
- Graduate or professional degree

General Social History

Which options below best describes your social situation?

- Supportive social network
- Few friends
- Substance-use based friends
- No friends
- Distant from family of origin
- Family conflict
- Other: _____

What is your current marital status?

- Single, never married
- Married/permanent relationship
- Divorced
- Separated
- Widowed

What is the status of your intimate relationship?

- Never been in a serious relationship
- Not currently in a 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
- Other: _____

What is your current living situation?

- Rent
- Own
- Group Home/IRTS facility
- Homeless
- Foster care

Who do you currently live with? (Please check all that apply)

- Live alone
- Roommates
- Partner/Spouse
- Parent(s)
- Sibling(s)
- Children
- Other:

Do you currently participate in spiritual activities?

- Yes
- No

If yes, do you have any spiritual beliefs related to your care that I should be aware of? (Please elaborate below.)

What is your current occupation status?

- Employed full-time
- Employed part-time
- Student
- Unemployed – seeking work
- Unemployed – not seeking work
- Disabled

Menstruation and Pregnancy History

At what age did you begin menstruation? _____

Which of these best describe your premenstrual symptoms?

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

Do you have a method of contraception? (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? _____