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PATIENT NAME: ______________________________________ DATE: _____________________

1. Please describe the main problem or symptom you are experiencing:
   ____
2. Please describe your problems or symptoms from the beginning:
   ____
   Describe how these symptoms make you feel:
   ____
   Severity on a scale of 1-10 (1 least, 10 most severe) Length of Symptoms
   ______________________________ ______________________________
   Was there a specific event that caused the symptoms to begin? If so, please list:
   ____
   What makes you feel worse or better?
   ____
3. Past Medical History
   Please check any illnesses or conditions that you have had or are having:

- ☐ Cancer/Type __________ ☐ Diabetes ☐ Glaucoma ☐ Tuberculosis
- ☐ Heart Trouble ☐ Syphilis ☐ Asthma ☐ Vein Trouble
- ☐ Jaundice ☐ Gonorrhea ☐ Stroke ☐ Kidney Disease
- ☐ Bleeding Tendencies ☐ Pneumonia ☐ Nervous Disorder
- ☐ Rheumatic Fever ☐ Gastrointestinal Disorder
- ☐ Other, please list: ____

Please check any problems or conditions that you are currently having or have had:

- ☐ eyesight ☐ cardiovascular ☐ respiratory ☐ ear, nose, or throat condition
- ☐ gynecologic ☐ neurological ☐ endocrine ☐ gastrointestinal
- ☐ breast issues ☐ blood pressure ☐ weight ☐ sexual dysfunction/changes
- ☐ chronic pain ☐ HIV positive/AIDS ☐ head injury ☐ liver damage or hepatitis
- ☐ fibromyalgia ☐ psychiatric ☐ neurological ☐ dermatological
- ☐ musculoskeletal, orthopedic, or painful joints ☐ hematologic/lymphatic condition
- ☐ loss of appetite ☐ migraine or cluster headaches ☐ allergic or immunologic condition

a. Have you had any allergy or sensitivity to medicines or other substances? Yes☐ No☐
   Medication/Substance: ___________________ Symptoms _____________________
   Medication/Substance: ___________________ Symptoms _____________________
b. Previous surgeries and dates: ____
c. Any serious injuries or broken bones? Yes ☐ No ☐
   If yes, please list with dates: ____
d. Have you had any dental problems, currently or in the past? Yes ☐ No ☐
   If yes, please list with dates: ____
e. Last menstrual cycle: _____ Periods are ☐ regular ☐ irregular #of pregnancies ____ # of miscarriages _____
   Are you currently using contraceptives? Yes ☐ No ☐
   Have you ever had a blood transfusion? Yes ☐ No ☐
f. Current Medication

Name of Medication	Dosage	How many times a day?	On this for how long?	Side Effects? Working?	Prescribing Physician

4. Personal History
   a. Where were you born? ____
   b. How would you describe your upbringing? ____________________________________
   c. Race/Ethnicity ☐ American Indian ☐ Asian ☐ African American ☐ Hispanic ☐ Caucasian ☐ Other
   d. Educational Background- please list any degrees you have achieved: ______________
   e. Current Employment Status- please check one from each category (a,b, and c):

a. Employment Status	b. Student Status	c. Volunteer Status
☐ unemployed, not looking	☐ part-time	☐ volunteer part-time
☐ unemployed, looking	☐ full-time	☐ volunteer full-time
☐ full-time ☐ part-time	☐ not a student	☐ no volunteer work
☐ self-employed ☐ retired		
☐ disabled ☐ on welfare		

   f. Religious Affiliation: ___________________ Military Background: ___________________
   g. Marital Status ☐ single ☐ married ☐ separated ☐ widowed ☐ divorced ☐ partnered
      # of marriages ____ # of children ____ length of time cohabitating with partner ______
   h. Current Residence ☐ own house/condo ☐ renting ☐ retirement complex
      Who lives with you: ____
   i. Are you currently or have you ever been involved in a lawsuit? ____________________
   j. Current Tobacco Use ☐ Yes ☐ No In the past? ☐ Yes ☐ No
      type/daily amount _______________ how long _______________

k. Do you drink alcoholic beverages? ☐ Yes ☐ No
type/daily amount ______________ weekly amount _________ how long ___________

l. Do you use illicit drugs? ☐ Yes ☐ No
type/daily amount ______________ weekly amount _________ how long ___________

m. Do you drink coffee/caffeine? ☐ Yes ☐ No
daily amount ______________ weekly amount _________ how long ___________

n. Have you heard or seen things that others have not/hallucinations/paranoia? ☐ Yes ☐ No

o. Have you experienced homicidal ideation? ☐ Yes ☐ No

p. Have you experienced suicidal ideation? ☐ Yes ☐ No

q. Are you experiencing memory loss/problems? ☐ Yes ☐ No
Language/Speech problems? ☐ Yes ☐ No

r. Do you have any explanation for your symptoms? ______________________________

5. Have you been diagnosed with a mental illness or sought psychiatric services in the past?
☐ Yes ☐ No If yes, please explain: ____

6. Family History
Please check any illnesses that your parents, grandparents, or siblings have had:

☐ Mental Illness ☐ Alcohol Abuse ☐ Drug/Substance Abuse

☐ Diabetes ☐ Nervous Disorder ☐ Cardiovascular Disease

☐ Cancer/type ______________ ☐ Other __________________________

7. Do you have specific goals for treatment? ☐ Yes ☐ No
If yes, please list:

____

____

____

____

____

8. How would you describe your mood, recent and long term?

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____

HEIGHT: _______________ WEIGHT: _______________