Adult Psychiatry Clinic

New Patient Intake Information

Welcome to the Adult Psychiatry Clinic! Our approach to treating you is comprehensive and thorough. We consider various factors that contribute to your well-being including mental, emotional, physical and spiritual health, stress, support systems, nutrition, and physical activity. This intake form provides vital information about you and your lifestyle. We hope you find that although the intake form is lengthy and requires an investment in time, it will allow us to understand you and provide the best treatment.

To fill out this intake form, please allow at least 45 minutes so you can answer all of the questions accurately. All of the questions are very important for your psychiatrist to know about, so please take your time and answer as carefully as you can. Because of our comprehensive approach, please allot 90 minutes for the first appointment.

Please bring the following with you to the first appointment, if available:

- ✓ Relevant medical documents
- ✓ Recent laboratory results
- ✓ All bottles/packages for all medications you are **currently** taking including prescribed medications, over the counter medications, and vitamin or nutritional supplements.

Thank you for choosing the Adult Psychiatry Clinic. We look forward to working with you.

Today's Date: _____/_____/_____
Month Day Year

BACKGROUND AND CONTACT INFORMATION

Patient's Name: _____
First Middle Last

Date of Birth: _____/_____/_____ Gender: ☐ Male ☐ Female
Month Day Year

Best contact telephone number: (_____)_____-_____

☐ Check if a voicemail can be left at this number

OTHER HEALTH AND MENTAL HEALTH PROVIDERS

Primary Care Provider

Name: _____

Phone: (_____)_____-_____

Counselor/ Therapist

Name: _____

Phone: (_____)_____-_____

Psychiatrist

Name: _____

Phone: (_____)_____-_____

CURRENT CONCERNS

Please describe your problem (s) (that is, the concerns that brought you here today):

When did these problems begin?

Please give examples of the problem:

Why do you think you're having this particular problem?

What are your goals for consulting with our clinic? That is, what would you like to happen?

1._____

2. _____

3. _____

4. _____

LIFE STRESS

Major Stresses: Please mark if any of the following events have happened to you in the past TWO YEARS? *Check all that apply.*

☐ Evicted, foreclosure, or loss of housing

☐ New housing

☐ Trouble with police

☐ Incarceration

☐ Partner: Trouble with police

☐ Partner: Incarceration

☐ Demotion or loss of employment

☐ Promotion or new job

☐ Partner: demotion or loss of employment

☐ Partner: promotion or new job

☐ Change in financial status

☐ More arguments with partner

☐ Separation or divorce

☐ Ended relationship with partner

☐ New marriage

☐ New romantic partner

☐ Increased absence of partner

☐ Loss of a close friend

☐ Major personal injury/illness

☐ Partner, family member, or friend: serious illness

☐ Death of a parent, family member, or friend

☐ Trouble with boss

☐ Trouble with teacher

☐ Trouble with coworkers

☐ Trouble with family

☐ Trouble with children

☐ Failing grades or academic stress

☐ Recent pregnancy

☐ Recent birth of child

☐ Loss of a pet

What feelings do you MOST OFTEN have when faced with stress or other problems (i.e. anger, fear, sadness, etc.)

What seems to help you deal with stress or problems?

What seems to make things worse?

SLEEP

Where do you sleep? *Please check all that apply.*

☐ Own bed

☐ Share a bed. If so, with whom? _____

☐ Other (ex: couch, floor, etc.)

What time do you usually go to bed on SCHOOL/WORK nights? _____

What time do you usually go to bed on WEEKENDS?_____

How long (in minutes) does it usually take you to fall asleep each night?

☐ 15 minutes or less ☐ 31 – 60 minutes

☐ 16 – 30 minutes ☐ 61 minutes or more

Problems falling asleep? ☐ No ☐ Yes

If yes, please describe: _____

Problems staying asleep? ☐ No ☐ Yes

If yes, please describe: _____

On average, how many hours do you sleep at night?

☐ Less than 6 hours ☐ 7 – 8 hours ☐ 9 hours ☐ 10 hours ☐ More than 10 hours

What time do you usually wake up on SCHOOL/WORK days? _____

What time do you usually wake up on WEEKENDS? _____

Problems waking up? ☐ No ☐ Yes

If yes, please describe: _____

How often do you take a nap?

☐ Never ☐ 1 – 2 days per week ☐ 3 – 6 days per week ☐ Every day

There is a television in my bedroom. ☐ No ☐ Yes

Do you use any nighttime medical devices (such as a CPAP, mouth guard, etc.)? ☐ No ☐ Yes

Any current or history of: *Check all that apply*

☐ Loud Snoring
☐ Sleep Terrors
☐ Awaken gasping for breath or choking
☐ Restless Sleep
☐ Irresistible urge to move legs or arms
☐ Sleepy during the day
☐ Grinds teeth
☐ Mouth Breathing
☐ Sleep Walking
☐ Recurrent nightmares
☐ Observed apnea (stops breathing) while sleeping
☐ Pain in legs at night

LIFESTYLE (Diet, Physical Activity, Sleep, Screen Time)

A. Diet and Nutrition

Do you have food allergies or sensitivities? ☐ No ☐ Yes

If yes, please list all food allergies and reaction: _____

Are you currently on a special diet (e.g., vegetarian, vegan, high protein, gluten free?) ☐ No ☐ Yes

If yes, please list dietary restrictions: _____

How many mornings per week do you eat breakfast?

☐0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

The next questions ask about the amount of certain foods and beverages you eat on an **AVERAGE DAY**.

Soda (glasses, cups, or cans of Coke, Pepsi, etc)

☐ None ☐ 1 ☐ 2 or more

Caffeinated tea (8 ounce cups of iced tea or hot tea)

☐ None ☐ 1 ☐ 2 or more

Caffeinated coffee (8 ounce cups)

☐ None ☐ 1 ☐ 2 or more

Energy drinks (cans, glasses, or cups)

☐ None ☐ 1 ☐ 2 or more

Fast Food

☐ None ☐ 1 ☐ 2 or more

Restaurant meals (including take out)

☐ None ☐ 1 ☐ 2 or more

Prepackaged meals (including frozen meals)

☐ None ☐ 1 ☐ 2 or more

Servings of fruit

☐ None ☐ 1-2 ☐ 2-3 ☐ 4-5 ☐ More than 5

Servings of vegetables

☐ None ☐ 1-2 ☐ 2-3 ☐ 4-5 ☐ More than 5

The next questions ask about the amount of certain foods and beverages you eat on an **AVERAGE WEEK**.

Servings of fish

☐ None ☐ 1 ☐ 2 or more

Servings of red meat

☐ None ☐ 1 ☐ 2 or more

Servings of nuts

☐ None ☐ 1 ☐ 2 or more

Servings of flaxseed

☐ None ☐ 1 ☐ 2 or more

B. Physical Activity and Exercise

How many **days per WEEK** do you spend at least **60 minutes** in moderate to high intensity physical exercise that makes you breathe hard and increases heart rate (ex: running, swimming, riding a bicycle, playing sports, etc.):

☐ None ☐1-2 days ☐ 3-4 day ☐ 5-6 days ☐ 7 days

How many **days per WEEK** do you spend at least **30 minutes** in moderate to high intensity physical exercise that makes you breathe hard and increases heart rate (ex: running, swimming, riding a bicycle, playing sports, etc.):

☐ None ☐1-2 days ☐ 3-4 day ☐ 5-6 days ☐ 7 days

How many **days per WEEK** do you spend at least **60 minutes** in low intensity physical exercise that makes you breathe a little harder and mildly increases heart rate (ex: yoga, hiking, walking, etc.):

☐ None ☐1-2 days ☐ 3-4 day ☐ 5-6 days ☐ 7 days

How many **days per WEEK** do you spend at least **30 minutes** in low intensity physical exercise that makes you breathe a little harder and mildly increases heart rate (ex: yoga, hiking, walking, etc.):

☐ None ☐1-2 days ☐ 3-4 day ☐ 5-6 days ☐ 7 days

Do you have a meditation practice? ☐ No ☐ Yes

If yes, please describe: _____

C. Screen Time

For an average day, how many hours do you spend:

Watching television: _____ hours

Playing video games: (include online games, X Box, Play Station, iPad/tablet, iPhone/smartphone _____ hours

Using a computer (ex: for school work, searching the internet, emailing, Skype. DO NOT include video games) _____ hours
Cell phone, other electronic device (ex: for texting, talking with friends, etc) _____ hours

MEDICATIONS

Prescription Medications

What prescription medication are you currently taking? Include all medications that have been prescribed by a doctor or other health care provider. *Include all CURRENT psychiatric medications*. (Please bring all medication bottles to your first visit!)

Name of Medication	Strength (Ex: 50 mg, 5 units)	Dose (Ex: 1 capsule daily, 1 tablet twice a day)	Reason Started	Side Effects

If more room is needed, please use the back of the page.

Vitamins, Minerals, Supplements, Over-the-Counter Medications.

Please list all the vitamins, minerals, herbal medicines, and over the counter medications (ex: Tylenol) that you are currently taking. (Please bring all bottles to your first visit)!

Name of Supplement or Over-the-Counter Medication	Strength (Ex: 50 mg, 5 units)	Dose (Ex: 1 capsule daily, 1 tablet twice a day)	Reason Started	Side Effects

If more room is needed, please use the back of the page.

Past Psychiatric Medications

What prescription psychiatric medications have been tried with your child in the PAST? Include all medications that have been prescribed by a doctor or other health care provider. (if you have them, please bring all medication bottles to your first visit!)

Name of Past Psychiatric Medication	Strength (Ex: 50 mg, 5 units)	Dose (Ex: 1 capsule daily, 1 tablet twice a day)	Reason Started	Side Effects

Name of Past Psychiatric Medication	Strength (Ex: 50 mg, 5 units)	Dose (Ex: 1 capsule daily, 1 tablet twice a day)	Reason Started	Side Effects

If more room is needed, please use the back of the page.

PAST PSYCHIATRIC OR MENTAL HEALTH CARE

Have you EVER seen a therapist or counselor before (e.g., psychologist, social worker, therapist, or counselor)? ☐ No ☐ Yes

If yes, when and why: _____

Have you EVER seen a psychiatrist before? ☐ No ☐Yes

If yes, when and why: _____

_____

Have you EVER received alcohol or drug treatment? ☐ No ☐Yes

If yes, when and why: _____

_____

Have you EVER been admitted to the hospital for psychiatric treatment? ☐ No ☐ Yes

If yes, when and why: _____

_____

Have you EVER tried to harm yourself? ☐ No ☐ Yes

If yes, when and why: _____

_____

Have you EVER attempted suicide? ☐ No ☐ Yes

If yes, when and why: _____

_____

Have you EVER tried to significantly or severely physically harm another person? ☐ No ☐ Yes

If yes, when and why: _____

_____

MEDICAL HISTORY

Do you have any CURRENT medical problems? ☐ No ☐ Yes

If yes, please describe: _____

_____

Do you have a history of:

☐ Seizures

☐ Concussions

☐ Head traumas

☐ Loss of consciousness

☐ Palpitations (rapid heart beat)

☐ Heart murmur

☐ Rheumatic fever

☐ High blood pressure

☐ Chest pain or shortness of breath with exercise

☐ High cholesterol

☐Diabetes

Do you have a history of eczema: ☐ No ☐ Yes

If yes, when diagnosed: _____

Do you have a history of reflux: ☐ No ☐ Yes

Other PAST medical problems: _____

Drug allergies/intolerances: _____

_____

History of surgeries: _____

_____

Do you use tobacco? ☐ No ☐ Yes

If yes, please answer the following:

What form of tobacco?_____

How much do you use?_____

When did you first start using tobacco?_____

Do you drink alcohol? ☐ No ☐ Yes

If yes, please answer the following:

What is your average **daily** consumption?_____

What is your average **weekly** consumption?_____

How many blackouts have you experienced?_____

What type of withdrawal symptoms do you experience?_____

Do you use any illicit drugs (including marijuana)? ☐ No ☐ Yes

If yes, please answer the following:

What type of illicit substances?_____

How much do you use?_____

How do you use it (such as smoking, snorting, IV, etc.)?_____

When did you first start using?_____

Have you ever experienced consequences from your substance use? _____

_____

Were there any complications or stressful events during your mother's pregnancy with you?_____

_____

Did your mother use tobacco, alcohol, marijuana, or any other illicit drugs while pregnant with you?___

_____

Was your mother depressed during or after pregnancy?_____

FOR WOMEN:

How many times have you been pregnant? _____

How many children do you have? _____

Are your menstrual cycles:

☐ Regular (every 28 days) ☐ Not regular (ex: 3 weeks, 5 weeks)

Do you have significant mood changes with your monthly cycles? ☐ No ☐ Yes

If yes, please describe: _____

What form of birth control do you use? _____

DEVELOPMENTAL HISTORY

If you can recall, please record your own childhood developmental milestones.

Crawled	☐Early	☐Normal	☐Late
Walked without assistance	☐Early	☐Normal	☐Late
Bowel trained	☐Early	☐Normal	☐Late
Bladder trained, day	☐Early	☐Normal	☐Late
Bladder trained, night	☐Early	☐Normal	☐Late
Tied shoelaces	☐Early	☐Normal	☐Late
Rode bicycle	☐Early	☐Normal	☐Late
Spoke first words	☐Early	☐Normal	☐Late

Did you experience any problems with vocabulary, articulation, or comprehension of language?

☐ No ☐ Yes

If yes, please describe: _____

Did you experience any problems with relationships with parents or family members as a child?

☐ No ☐ Yes

If yes, please describe: _____

Did you experience any problems with relationships with peers or friends as a child?

☐ No ☐ Yes

If yes, please describe: _____

Temperament

Everyone is BORN with a natural form of interacting with people, places, and things. This is called "temperament." How would you described your temperament through childhood, adolescence, and adulthood?

- **Easy or flexible** – described as generally calm, happy, regular in sleeping and eating habits, adaptable, and not easily upset. Because of your easy style, you do not easily share your frustrations or hurt.

- **Difficult, active, or feisty –** described as fussy or irritable, irregular in eating and sleeping habits, fearful of new people and situations, easily upset by noise and commotion, high strung, and intense in interpersonal relationships.

- **Slow to warm up or cautious –** described as relatively inactive and fussy, tend to withdraw or react negatively to new situations, but your reactions gradually become more positive with continuous exposure to a situation.

Do you have any fears or phobias (ex: flying, snakes, clowns, etc.) ☐ No ☐ Yes

If yes, please describe: _____

Were there any safety concerns in your house or neighborhood while you were a child, or later as an adult? ☐ No ☐ Yes

If yes, please describe: _____

REVIEW OF SYSTEMS

Please indicate if you have any of the following physical symptoms within the **past month**. *Check all that apply.*

General
□ Fever
□ Fatigue
□ Recent weight loss or gain
□ Restriction of numerous foods
□ Heat or cold intolerance
□ Difficulty sleeping

Head, Eyes, Ears, Nose, Mouth, Throat
□ Headache
□ Dizziness
□ Loss of hair
□ Swollen glands
□ Red or irritated eyes
□ Ringing in ears
□ Dry mouth
□ Bad breath
□ Mouth sores
□ Sore throat
□ Voice changes
□ Runny nose
□ Post nasal drip

Respiratory
□ Shortness of breath
□ Wheezing
□ Chest pain on taking a deep breath
□ Other chest pain or tightness
□ Cough

Genitourinary
□ Pain with urination
□ Increase in frequency or urgency in urinating
□ Blood in urine

Cardiovascular
□ Irregular heart beat
□ Murmur
□ Palpitations

Bones, Muscles, Joints
□ Morning stiffness
□ Joint pain
□ Joint swelling
□ Muscle pain
□ Neck pain
□ Low back pain
□ Numbness or tingling

Skin
□ Rash over cheeks
□ Hives or welts
□ Easy bruising
□ Sun sensitivity
□ White, blue, or red skin color change in fingers when exposed to cold
□ Strong foot odor

Gastrointestinal
□ Loss of appetite
□ Difficulty swallowing
□ Heartburn, indigestion
□ Nausea
□ Vomiting
□ Pain or cramps in abdomen
□ Abnormal stool patterns
□ Bloated abdomen and gas/burping
□ Diarrhea
□ Constipation
□ Blood in stool
□ Vomiting blood

Other: _____

FAMILY HISTORY

A. Biological Mother

Biological mother's current age:_____

If deceased, age at death and cause of death: _____

Biological mother's race/ethnicity:

☐ American Indian / Native American / Alaska Native

☐ Asian or Asian American

☐ Black / African American

☐ Hispanic / Latina

☐ White / Caucasian

☐ Hawaiian or Other Pacific Islander

☐ Other_____

☐ Unknown

Biological mother's **highest** level of **completed education**?

☐ Elementary school only (grades 1-8)

☐ Some high school, but did not finish (grades 9-11)

☐ Completed high school or GED (high school graduate)

☐ Some college, but have not completed a degree

☐ Two-year college degree / A.A / A.S.

☐ Four-year college degree / B.A. / B.S.

☐ Some graduate work but have not completed a degree

☐ Completed a Masters degree or professional degree (e.g., ARNP)

☐ Completed a Ph.D., law degree, M.D., or similar advanced professional degree

Biological mother's **current employment** status?

☐ Employed full time

☐ Employed part time

☐ Unemployed / Looking for work

☐ Homemaker

☐ Retired

☐ N/A

If employed full or part time, what is your biological mother's **occupation or type of work**?_____

_____

_____

Please describe the **medical** problems your biological mother may have:_____

_____

_____

Please describe any **behavioral/emotional problems** your biological mother may have:_____

_____

_____

Has your biological mother ever sought psychiatric treatment? · No · Yes

If **yes**, please explain the purpose:_____

_____

Has your biological mother ever had treatment or counseling for alcohol or drug use? · No · Yes

If **yes**, please explain:_____

_____

Does/has **anyone** on your biological mother's side of the family…:

Take psychiatric medications? · No · Yes

If **yes**, who, what medications, and why?_____

_____

Ever been hospitalized for a psychiatric problem? · No · Yes

If **yes**, who and why?_____

_____

Ever been hospitalized for alcoholism or drug abuse? · No · Yes

If **yes**, who and why? _____

_____

Ever **attempted** suicide or homicide? · No · Yes

If **yes**, who? :_____

_____

Ever **committed/completed** suicide or homicide? · No · Yes

If **yes**, who? :_____

B. Biological Father

Biological father's current age:_____

If deceased, age at death and cause of death:_____

Biological father's race/ethnicity:

☐ American Indian / Native American / Alaska Native

☐ Asian or Asian American

☐ Black / African American

☐ Hispanic / Latina

☐ White / Caucasian

☐ Hawaiian or Other Pacific Islander

☐ Other_____

☐ Unknown

Biological father's **highest** level of **completed education**?

☐ Elementary school only (grades 1-8)

☐ Some high school, but did not finish (grades 9-11)

☐ Completed high school or GED (high school graduate)

☐ Some college, but have not completed a degree

☐ Two-year college degree / A.A / A.S.

☐ Four-year college degree / B.A. / B.S.

☐ Some graduate work but have not completed a degree

☐ Completed a Masters degree or professional degree (e.g., ARNP)

☐ Completed a Ph.D., law degree, M.D., or similar advanced professional degree

Biological father's **current employment** status?

☐Employed full time

☐ Employed part time

☐ Unemployed / Looking for work

☐ Homemaker

☐ Retired

☐ N/A

If employed full or part time, what is your biological father's **occupation or type of work**?_____

_____

_____

Please describe the **medical** problems your biological father may have:_____

_____

_____

Please describe any **behavioral/emotional problems** your biological father may have:_____

_____

_____

Has your biological father ever sought psychiatric treatment? · No · Yes

If **yes**, please explain the purpose:_____

_____

Has your biological father ever had treatment or counseling for alcohol or drug use? · No · Yes

If **yes**, please explain:_____

_____

Does/has **anyone** on your biological father's side of the family…:

Take psychiatric medications? · No · Yes

If **yes**, who, what medications, and why?_____

_____

Ever been hospitalized for a psychiatric problem? · No · Yes

If **yes**, who and why?_____

_____

Ever been hospitalized for alcoholism or drug abuse? · No · Yes

If **yes**, who and why? _____

_____

Ever **attempted** suicide or homicide? · No · Yes

If **yes**, who? :_____

_____

Ever **committed/completed** suicide or homicide? · No · Yes

If **yes**, who? :_____

If you are not adopted, please SKIP this section, and resume at "Family Medical History" on page 24.

When did your adoptive parents first enter into your life? _____

Are you related to your adoptive parents (grandparents, aunt/uncle)?

· No · Yes If **yes**, how related? _____

C. Non-Biological Mother (In the following questions, "mother" refers to the foster mother or adoptive mother.)

Mother's current age:_____

If deceased, age at death and cause of death:_____

Mother's race/ethnicity:

☐ American Indian / Native American / Alaska Native

☐ Asian or Asian American

☐ Black / African American

☐ Hispanic / Latina

☐ White / Caucasian

☐ Hawaiian or Other Pacific Islander

☐ Other_____

☐ Unknown

Mother's **highest** level of **completed education**?

☐ Elementary school only (grades 1-8)

☐ Some high school, but did not finish (grades 9-11)

☐ Completed high school or GED (high school graduate)

☐ Some college, but have not completed a degree

☐ Two-year college degree / A.A / A.S.

☐ Four-year college degree / B.A. / B.S.

☐ Some graduate work but have not completed a degree

☐ Completed a Masters degree or professional degree (e.g., ARNP)

☐ Completed a Ph.D., law degree, M.D., or similar advanced professional degree

Mother's **current employment** status?

☐Employed full time

☐ Employed part time

☐ Unemployed / Looking for work

☐ Homemaker

☐ Retired

☐ N/A

If employed full or part time, what is your mother's **occupation or type of work**?_____

_____

Please describe the **medical** problems your mother may have:_____

_____

_____

Please describe any **behavioral/emotional problems** your mother may have:_____

_____

_____

Has your mother ever sought psychiatric treatment? · No · Yes

If **yes**, please explain the purpose:_____

_____

Has your mother ever had treatment or counseling for alcohol or drug use? · No · Yes

If **yes**, please explain:_____

_____

Does/has **anyone** on your mother's side of the family…:

Take psychiatric medications? · No · Yes

If **yes**, who, what medications, and why?_____

_____

Ever been hospitalized for a psychiatric problem? · No · Yes

If **yes**, who and why?_____

_____

Ever been hospitalized for alcoholism or drug abuse? · No · Yes

If **yes**, who and why? _____

_____

Ever **attempted** suicide or homicide? · No · Yes

If **yes**, who? :_____

Ever **committed/completed** suicide or homicide? · No · Yes

If **yes**, who? :_____

B. Non-Biological Father (In the following questions, "father" refers to the foster or adoptive father.)

Father's current age:_____

If deceased, age at death and cause of death:_____

Father's race/ethnicity:

☐ American Indian / Native American / Alaska Native

☐ Asian or Asian American

☐ Black / African American

☐ Hispanic / Latina

☐ White / Caucasian

☐ Hawaiian or Other Pacific Islander

☐ Other_____

☐ Unknown

Father's **highest** level of **completed education**?

☐ Elementary school only (grades 1-8)

☐ Some high school, but did not finish (grades 9-11)

☐ Completed high school or GED (high school graduate)

☐ Some college, but have not completed a degree

☐ Two-year college degree / A.A / A.S.

☐ Four-year college degree / B.A. / B.S.

☐ Some graduate work but have not completed a degree

☐ Completed a Masters degree or professional degree (e.g., ARNP)

☐ Completed a Ph.D., law degree, M.D., or similar advanced professional degree

Father's **current employment** status?

☐Employed full time

☐ Employed part time

☐ Unemployed / Looking for work

☐ Homemaker

☐ Retired

☐ N/A

If employed full or part time, what is your father's **occupation or type of work**?_____

_____

_____

Please describe the **medical** problems your father may have:_____

_____

Please describe any **behavioral/emotional problems** your father may have:_____

_____

_____

Has your father ever sought psychiatric treatment? · No · Yes

If **yes**, please explain the purpose:_____

_____

Has your father ever had treatment or counseling for alcohol or drug use? · No · Yes

If **yes**, please explain:_____

_____

Does/has **anyone** on your father's side of the family…:

Take psychiatric medications? · No · Yes

If **yes**, who, what medications, and why?_____

_____

Ever been hospitalized for a psychiatric problem? · No · Yes

If **yes**, who and why?_____

_____

Ever been hospitalized for alcoholism or drug abuse? · No · Yes

If **yes**, who and why? _____

_____

Ever **attempted** suicide or homicide? · No · Yes

If **yes**, who? :_____

_____

Ever **committed/completed** suicide or homicide? · No · Yes

If **yes**, who? :_____

FAMILY MEDICAL HISTORY

Does anyone in your **BIOLOGICAL FAMILY** have a history of:

Sudden or unexplained death in someone young?	· No	· Yes
Sudden cardiac death or "heart attack" in members younger than 35 years of age?	· No	· Yes
Sudden death during exercise?	· No	· Yes
Cardiac arrhythmias?	· No	· Yes
Hypertropic cardiomyopathy or other cardiomyopathy?	· No	· Yes
Long QT syndrome, short-QT syndrome or Brugada syndrome?	· No	· Yes
Wolff-Parkinson-White syndrome?	· No	· Yes
Marfan syndrome?	· No	· Yes
Celiac disease?	· No	· Yes
Diabetes?	· No	· Yes

If **yes**, please describe: _____

HOUSING AND HOUSEHOLD

What is your marital status?

· Single · In a serious relationship · Married · Divorced · Widow

How many times have you been married? _____

How many children do you have? _____

Which of the following best describes your **current** housing situation?

· Own single/multiple family home
· Rented house
· Rented apartment
· Subsidized housing
· Group home
· Shelter
· Homeless
· Other: _____

What is the **primary language** spoken in the home?_____

Are there any firearms in the home? · No · Yes

If **yes**, how are these secured?_____

Do you have any concerns about the security or safety of your home or neighborhood? · No · Yes

If **yes**, please describe:_____

Do you have any pets in the home? · No · Yes

If **yes**, please describe:_____

Who are the individuals living in your home? *Please include ALL adults and children*

Name	Relationship	Age

If more room is needed, please use the back of the page.

Does your family attend religious services? · No · Yes

If **yes**, please describe:_____

What religious/spiritual dimensions should we consider in planning your care, if any? _____

_____

SCHOOL AND EMPLOYMENT HISTORY

Are you currently in school? · No · Yes

If **yes**, please describe:_____

What is your highest completed level of education?

- Graduate school
- 4-year college
- 2-year college
- Trade school
- High school
- GED
- _____ Grade

Which best describes your overall academic performance?

- A's and B's
- B's and C's
- C's and D's
- D's and F's
- Other, please describe:___

_____

Were you ever diagnosed with a learning disability or received specific accommodations (such as 504 plan or IEP)? · No · Yes

If **yes**, please describe:_____

Are you currently employed? · No · Yes

If **yes**, please describe:_____

Do you currently or have you ever served in the U.S. Military? · No · Yes

If **yes**, when and which branch?_____

Please provide your previous employment history, starting with your current or most recent employment:

Duration of Employment	Position Title or Type of Work	Occupational Stressors/Difficulties

If more room is needed, please use the back of the page.

LEGAL

Has the Department of Child Safety (previously known as Child Protective Services) ever been involved in your family's life as an adult or a child? · No · Yes

If **yes**, please describe:_____

_____

Do you have a history with the legal system, such as previous arrests or incarcerations, as a youth or an adult? · No · Yes

If **yes**, please describe:_____

_____

ADDITIONAL INFORMATION

Is there any additional information you would like us to know or which you believe will be helpful to better understand you?

Thank you for choosing the Banner University Medical Center Adult Psychiatry Clinic. We look forward to working with you.