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: ______/______/______  
Month Day Year

Gender: □ Male  □ Female

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  ☐ Increased absence of partner
☐ New housing  ☐ Loss of a close friend
☐ Trouble with police  ☐ Major personal injury/illness
☐ Incarceration  ☐ Partner, family member, or friend: serious illness
☐ Partner: Trouble with police  ☐ Death of a parent, family member, or friend
☐ Partner: Incarceration  ☐ Trouble with boss
☐ Demotion or loss of employment  ☐ Trouble with teacher
☐ Promotion or new job  ☐ Trouble with coworkers
☐ Partner: demotion or loss of employment  ☐ Trouble with family
☐ Partner: promotion or new job  ☐ Trouble with children
☐ Change in financial status  ☐ Failing grades or academic stress
☐ More arguments with partner  ☐ Recent pregnancy
☐ Separation or divorce  ☐ Recent birth of child
☐ Ended relationship with partner  ☐ Loss of a pet
☐ New marriage
☐ New romantic partner

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  ☐ Irresistible urge to move legs or arms  ☐ Sleep Walking
☐ Sleep Terrors  ☐ Sleepy during the day  ☐ Recurrent nightmares
☐ Awaken gasping for breath or choking  ☐ Grinds teeth  ☐ Observed apnea (stops breathing) while sleeping
☐ Restless Sleep  ☐ Mouth Breathing  ☐ 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 days
- □ 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 days
- □ 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 days
- □ 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 days
- □ 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!)

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Strength (Ex: 50 mg, 5 units)</th>
<th>Dose (Ex: 1 capsule daily, 1 tablet twice a day)</th>
<th>Reason Started</th>
<th>Side Effects</th>
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*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)!

<table>
<thead>
<tr>
<th>Name of Supplement or Over-the-Counter Medication</th>
<th>Strength (Ex: 50 mg, 5 units)</th>
<th>Dose (Ex: 1 capsule daily, 1 tablet twice a day)</th>
<th>Reason Started</th>
<th>Side Effects</th>
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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!)

<table>
<thead>
<tr>
<th>Name of Past Psychiatric Medication</th>
<th>Strength (Ex: 50 mg, 5 units)</th>
<th>Dose (Ex: 1 capsule daily, 1 tablet twice a day)</th>
<th>Reason Started</th>
<th>Side Effects</th>
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### 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

**Bones, Muscles, Joints**
- □ Murmur
- □ Palpitations
- □ 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 / 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]
- Hypertrophic 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 ☐ Subsidized housing ☐ Homeless ☐
- Rented house ☐ Group home ☐ Shelter ☐
- Rented apartment ☐

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*

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Age</th>
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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  
• Trade school  
• 4-year college  
• High school  
• 2-year college  
• GED  
• __________ Grade

Which best describes your overall academic performance?  
• A’s and B’s  
• C’s and D’s  
• B’s and C’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:

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<tr>
<th>Duration of Employment</th>
<th>Position Title or Type of Work</th>
<th>Occupational Stressors/Difficulties</th>
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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.