ADULT MEDICAL HISTORY QUESTIONNAIRE

The following questions are intended to elicit basic background information prior to our first visit. Much of this information will be discussed in greater detail during your appointment. Please leave questions blank if they do not pertain to you or if you do not feel comfortable answering.

Who referred you? _____

What is your primary concern? _____

Name _____
First Middle Last

Age _____ Date of Birth _____ Hometown _____

Street Address _____

City _____ State _____ Zip _____

Cell Phone _____ Work Phone _____ Email _____

Highest Level of Education _____

Place of Employment _____ Occupation/Title _____ Hours/Week _____

If not working, are you ☐retired ☐disabled ☐sick leave ☐other (explain) _____

If you receive disability or SSI, for what disability? _____ and for how long? _____

Relationship Status _____

Height _____ Weight _____

Preferred Pharmacy (Name and Address) _____

EMERGENCY CONTACTS:
Name _____

Address (if different from above) _____

Cell Phone _____ Work Phone _____

Place of Employment _____

Relation _____

Name _____

Address (if different from above) _____

Cell Phone _____ Work Phone _____

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Place of Employment _____

Relation _____

List the names of all people currently residing in your home and provide details about each individual (age, relationship, school/occupational status).

NAME	AGE	RELATIONSHIP	SCHOOL STATUS AND/OR OCCUPATION
ex. John	*8 years old*	*Son*	*2nd grade at Smith Elementary School*

List dates of moves over the past 10 years and for what reasons.

How long at present address?

SYMPTOM CHECKLIST

Please check those items that pertain to you:

- ☐ Often feel sad
- ☐ Confused or feel like you're in a fog
- ☐ Day dream or get lost in your thoughts
- ☐ Low energy
- ☐ Social withdrawal
- ☐ Pessimistic outlook toward the future
- ☐ Excessive tearfulness or crying
- ☐ Unrealistic fears (Explain)
- ☐ Irritability
- ☐ Loneliness
- ☐ Easily made jealous
- ☐ Avoidance of being left alone
- ☐ Excessive need for reassurance
- ☐ Very self-conscious or easily embarrassed
- ☐ Often feel tense and unable to relax
- ☐ Frequent physical complaints (i.e. headaches, stomach aches, nausea)
- ☐ Overly concerned with future events

☐Nervous mannerisms (i.e. nail biting)
☐Perfectionism
☐Feelings of inadequacy
☐Panic – feelings of intense fear/discomfort with palpitations, tremors, shortness of breath, choking feelings, etc.
☐Obsessions – unwanted ideas, images or impulses that intrude on thinking despite efforts to resist them. (Fear of contamination, recurring doubts about danger, extreme concern with order, symmetry or exactness)
☐Can't get mind off certain thoughts
☐Recurrent thoughts about death or preoccupation with death
☐Suicidal thoughts
☐Suicide attempts
☐Strange thoughts or ideas (Explain)
☐Hallucinations – visual or auditory (Describe)
☐Inappropriate expression of feelings (ex. laughing at something sad)
☐Concern that people are out to get you
☐Severe mood changes (ex. very sad to very happy)
☐Deliberately harms self
☐Unstable relationships
☐Difficulty making or keeping friends
☐Avoidance of unfamiliar social situations
☐Concerns about sexual identity
☐Concerns about gender identity
☐Sexually promiscuous
☐Fail to finish things you start
☐Easily distracted
☐Difficulty concentrating
☐Shift excessively from one activity to another
☐Difficulty sitting still
☐Impulsive or act without thinking
☐Cigarette Smoking (how many packs per day?) (smoked for how long?)
☐Drug Abuse (what kind?)
☐Alcohol Abuse (what kind?)
☐Physically violent towards others
☐Physically violent towards property (vandalism, destructive)
☐Firesetting
☐Stealing, Shoplifting, Breaking and Entering
☐Frequent Lying
☐Any involvement with justice system or legal problems

☐Sleep difficulties (sleepwalking, restless, inability to fall asleep or sleep too much) (Explain)
☐Eating difficulties (difficulty keeping food down, overeat, don't have much of an appetite, fear of trying new foods, tremendous concern about weight) (Explain)
☐Poor personal hygiene (difficulty keeping yourself clean or lack of interest in appearance)
☐Tics (sudden rapid, recurrent motor movements or vocalizations)

PSYCHIATRIC/PSYCHOLOGICAL/MEDICAL HISTORY

List all doctors and mental health professionals who have examined and/or treated you.
Please give name and phone number for each.

Family Physician/Primary Care Physician _____

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Previous Psychiatrist(s) _____

Therapist(s) or Counselor(s) _____

Other Physician(s) _____

Other (list type of provider and contact information) _____

List all previous psychiatric diagnoses given _____

List all other medical conditions/diagnoses _____

List medications you have been on in the past (not taking currently) for mood or behavior. Please include length of time taken and dose, if known. Please refer to the medication list at the end of this document, if needed.

Medication	Dose	Taken for how long?	Reason for stopping

What medication(s) are you taking now? Please include all medications, not just those for mood or behavior. Please refer to the medication list at the end of this document, if needed.

Medication	Dose	Taken for how long?	Reason for taking

List any allergic reactions to medications

If you have ever been **hospitalized,** please explain when and for what reason.

Name of Hospital	Year	Reason/Diagnosis

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Please check if any of the following pertain to you and explain (use text box below)

- ☐Heart Disease
- ☐Lung Disease
- ☐Liver Disease
- ☐Jaundice
- ☐Seizures
- ☐Fainting
- ☐Asthma
- ☐Dietary problems
- ☐Hearing problems
- ☐Urinary problems
- ☐Nausea or vomiting
- ☐Drug or alcohol abuse
- ☐Diarrhea (frequently)
- ☐Diabetes
- ☐Tonsillectomy
- ☐Dental problems
- ☐Skin Disease
- ☐Irregular Sleep Patterns
- ☐Visual problems
- ☐Bowel or elimination problems
- ☐Concussions or traumatic brain injury
- ☐Genetic Syndrome
- ☐Neurological testing or problem
- ☐High fevers
- ☐Injuries or broken bones
- ☐Recent weight gain or loss
- ☐Activity limitations
- ☐Snoring
- ☐Speech problems
- ☐Other

Explain any checkmarks above

GYNECOLOGY

- ☐Pregnancy (if so, when)
- ☐Abortion (if so, when)
- ☐Miscarriage (if so, when)
- ☐Menstrual problems
- ☐Birth control (if so, what type)

FAMILY MEDICAL/PSYCHIATRIC HISTORY

Please check which, if any, of the following conditions/problems apply to your blood relatives. If other significant medical/psychiatric problems are present among blood relatives, please list those in the space provided below.

	Mother	Father	Brother(s)	Sister(s)	Maternal Grandma	Maternal Grandpa	Paternal Grandma	Paternal Grandpa
ADHD/ attentional problem	☐	☐	☐	☐	☐	☐	☐	☐
Childhood behavioral problems	☐	☐	☐	☐	☐	☐	☐	☐
Problems with aggression	☐	☐	☐	☐	☐	☐	☐	☐
Learning disability	☐	☐	☐	☐	☐	☐	☐	☐
Failed high school	☐	☐	☐	☐	☐	☐	☐	☐
Intellectual Disability	☐	☐	☐	☐	☐	☐	☐	☐
Autism	☐	☐	☐	☐	☐	☐	☐	☐
Psychosis/schizophrenia	☐	☐	☐	☐	☐	☐	☐	☐
Bipolar Disorder	☐	☐	☐	☐	☐	☐	☐	☐
Depression (greater than 2 weeks)	☐	☐	☐	☐	☐	☐	☐	☐
Suicide	☐	☐	☐	☐	☐	☐	☐	☐
Anxiety or adjustment disorder	☐	☐	☐	☐	☐	☐	☐	☐
Panic disorder	☐	☐	☐	☐	☐	☐	☐	☐
Other mental disorder (describe below)	☐	☐	☐	☐	☐	☐	☐	☐
Tic disorder or Tourette's	☐	☐	☐	☐	☐	☐	☐	☐
Heart Problem at a young age (<60)	☐	☐	☐	☐	☐	☐	☐	☐
Alcohol Abuse	☐	☐	☐	☐	☐	☐	☐	☐
Substance Abuse	☐	☐	☐	☐	☐	☐	☐	☐
Antisocial behavior (assault/thefts)	☐	☐	☐	☐	☐	☐	☐	☐
Arrests/incarcerations	☐	☐	☐	☐	☐	☐	☐	☐

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Physical abuse (victim)	☐	☐	☐	☐	☐	☐	☐	☐
Physical abuse (perpetrator)	☐	☐	☐	☐	☐	☐	☐	☐
Sexual abuse (victim)	☐	☐	☐	☐	☐	☐	☐	☐
Sexual abuse (perpetrator)	☐	☐	☐	☐	☐	☐	☐	☐

Other significant medical/psychiatric conditions in the family

I do certify that all the above information is true and complete.

NAME (typed name constitutes e-signature) _____

DATE _____

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PSYCHOTROPIC MEDICATION LIST (for reference)

ANTIDEPRESSANTS

- ☐ Amitriptyline (Elavil)
- ☐ Notriptyline
- ☐ Imipramine
- ☐ Clomipramine (Anafranil)
- ☐ Desipramine
- ☐ Doxepin
- ☐ Amoxapine
- ☐ Fluoxetine (Prozac)
- ☐ Citalopram (Celexa)
- ☐ Escitalopram (Lexapro)
- ☐ Paroxetine (Paxil)
- ☐ Sertraline (Zoloft)
- ☐ Fluvoxamine (Luvox)
- ☐ Venlafaxine (Effexor)
- ☐ Desvenlafaxine (Pristiq)
- ☐ Duloxetine (Cymbalta)
- ☐ Vortioxetine (Brintellix)
- ☐ Vilazodone (Viibryd)
- ☐ Bupropion (Wellbutrin)
- ☐ Mirtazapine (Remeron)
- ☐ Phenelzine (Nardil)

MOOD STABALIZERS

- ☐ Valproic Acid (Depakote)
- ☐ Lamotrigine (Lamictal)
- ☐ Carbamazepine (Tegretol)
- ☐ Oxcarbazepine (Trileptal)
- ☐ Topiramate (Topamax)
- ☐ Gabapentin (Neurontin)
- ☐ Lithium

ANXIETY MEDICATIONS

- ☐ Alprazolam (Xanax)
- ☐ Clonazepam (Klonopin)
- ☐ Lorazepam (Ativan)
- ☐ Diazepam (Valium)
- ☐ Chlordiazepoxide (Librium)
- ☐ Oxazepam (Serax)
- ☐ Hydroxyzine (Vistaril)
- ☐ Buspirone (Buspar)
- ☐ Pregabalin (Lyrica)

ANTIPSYCHOTICS

- ☐ Risperidone (Risperdal)
- ☐ Quetiapine (Seroquel)
- ☐ Olanzapine (Zyprexa)
- ☐ Ziprasidone (Geodon)
- ☐ Clozapine (Clozaril)
- ☐ Aripiprazole (Abilify)
- ☐ Paliperidone (Invega)
- ☐ Asenapine (Saphris)
- ☐ Iloperidone (Fanapt)
- ☐ Cariprazine (Vraylar)
- ☐ Brexpiprazole (Rexulti)
- ☐ Haloperidol (Haldol)
- ☐ Fluphenazine (Prolixin)
- ☐ Pimozide (Orap)
- ☐ Chlorpromazine (Thorazine)
- ☐ Perphenazine (Trilafon)
- ☐ Thioridazine
- ☐ Thiothixene (Navane)
- ☐ Trifluoperazine (Stelazine)

ADHD MEDICATIONS

- ☐ Adderall
- ☐ Vyvanse
- ☐ Dexedrine
- ☐ Methylphenidate (Ritalin)
- ☐ Concerta
- ☐ Focalin
- ☐ Adzenys XR (Amphetamine)
- ☐ Quillivant XR (Methylphenidate)
- ☐ Bupropion (Wellbutrin)
- ☐ Atomoxetine (Strattera)
- ☐ Clonidine (Catapres, Kapvay)
- ☐ Guanfacine (Tenex; Intuniv)

SLEEP MEDICATIONS

- ☐ Trazodone
- ☐ Zolpidem (Ambien)
- ☐ Zaleplon (Sonata)
- ☐ Eszopiclone (Lunesta)
- ☐ Ramelteon
- ☐ Triazolam (Halcion)
- ☐ Temazepam (Restoril)

SUBSTANCE USE TREATMENT

- ☐ Methadone
- ☐ Buprenorphine (Subutex)
- ☐ Disulfiram (Antabuse
- ☐ Naltrexone (Vivitrol)
- ☐ Bupropion (Zyban)
- ☐ Varenicline (Chantix)
- ☐ Acamprosate (Campra)