**Name:**

**Date of Birth**:       **Current Date**:

**CURRENT ISSUES**

**What are the basic problem(s) you are seeking help for?**

1.

2.

3.

4.

**What are your treatment goals?**

**Current Psychiatric Symptoms Checklist: (check Symptoms you experience currently or frequently)**

**Depressed mood**

**Unable to enjoy life**

**Sleeping Too Much**

**Sleeping Too Little**

**Early Waking**

**Trouble Falling Asleep**

**Unable to enjoy life**

**Loss of interest**

**Memory Problems**

**Excessive Guilty Feelings**

**Fatigue / Decreased Energy**

**Poor Concentration**

**Increased Appetite**

**Decreased Appetite**

**Weight Loss**

**Hearing Things / Psychosis**

**Suicidal Feelings**

**Decreased Sex Drive**

**Crying spells**

**Low Self-Esteem**

**Feelings of Hopelessness**

**Grandiosity**

**Irritabilty**

**Decrease need for sleep**

**Rapid Speech**

**Racing thoughts**

**Distractibility**

**Increased Drive**

**Physical Agitation**

**Increased Sex Drive**

**Spending Too Much Money**

**Increased Risk Taking**

**Excessive Energy**

**Excessive worry**

**Feeling Restless/ Keyed Up**

**Physical or Mental Fatigue**

**Poor Concentration**

**Irritability**

**Muscle Tension**

**Discrete Episode of Fear**

**Racing Heart**

**Sweating**

**Trembling**

**Shortness of Breath**

**Feeling of Choking**

**Chest Pain**

**Nausea**

**Dizziness**

**Derealization**

**Fear of being Crazy**

**Fear of Dying**

**Sensory Changes**

**Chills or Hot Flushes**

**Social Fears and Anxiety**

**Avoidance of Social Events**

**Obsessive Thinking**

**Compulsive Behaviors**

**Refusal to Maintain Weight**

**Irrational Fear over Weight**

**Disturbed Body Image**

**Loss of Your Period**

**Food Binging**

**Purging or Restriction**

**Hallucinations / Voices**

**Delusions**

**Disorganized Speech**

**Disorganized Behavior**

**Personality Blunting**

**Concentration Trouble**

**Careless Mistakes**

**Can’t Sustain Attention**

**Poor Listening**

**Failure to Finish**

**Instructions Difficulty**

**Poor Organizing Capacities**

**Avoids Mental Effort**

**Loses Things**

**Easily Distracted**

**Forgetful of daily activities**

**Constant Fidgets /Tapping**

**Getting Out of Seat**

**Difficulty with Quiet Time**

**Climbing**

**Excessive Talking**

**Difficultly Waiting for Turn**

**Blurting out Answers**

**Interrupts Others**

**Poor Self Esteem**

**Tendency to Frustration**

**Quitting Easily**

**Details Regarding the Above Symptoms:**

**SUICIDE RISK ASSESSMENT**

Have you ever had feelings or thoughts that you didn’t want to live? Y  N

If YES, please answer the following. If NO, please skip to ***Past Psychiatric History***

Do you **currently** feel that you don’t want to live? Y  N

How often do you have these thoughts?

When was the last time you had thoughts of dying?

Has anything happened recently to make you feel this way?

On a scale of 1 to 10, (ten being strongest) how strong is your desire to kill yourself currently?

Would anything make it better?

Have you ever thought about how you would kill yourself? Y  N  Details:

Is the method you would use readily available? Y  N

Have you planned a time for this? Y  N  Details:

Is there anything that would stop you from killing yourself? Y  N  Details:

Do you feel hopeless and /or worthless? Y  N

Have ever tried to kill or harm yourself before? Y  N  Details:

**PAST PSYCHIATRIC HISTORY**

**Have you previously engaged outpatient psychiatric treatment?** Y  N

Details:

**Have you ever been in the psychiatric hospital?** Y  N

Details:

**PERSONAL and FAMILY PAST PSYCH HISTORY:**

**Have you or a member of your family had of any of the following Diagnoses or Conditions?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Diagnosis / Condition | You | | Family | Details (if not explained elsewhere) |
| Now | Past |
| Depression |  |  |  |  |
| Suicidal Feeling |  |  |  |  |
| Suicide Attempt |  |  |  |  |
| Bipolar Disorder |  |  |  |  |
| Anxiety |  |  |  |  |
| Panic |  |  |  |  |
| Phobias |  |  |  |  |
| PTSD |  |  |  |  |
| Alcoholism |  |  |  |  |
| Drug Addiction |  |  |  |  |
| Assault/Rage |  |  |  |  |
| Psychosis |  |  |  |  |
| Schizophrenia |  |  |  |  |
| Anorexia |  |  |  |  |
| Bulemia |  |  |  |  |
| OCD |  |  |  |  |
| Hoarding |  |  |  |  |
| Dementia |  |  |  |  |
| ADHD |  |  |  |  |
| Dyslexia |  |  |  |  |
| Learning Disability |  |  |  |  |
| Autism/Asperger’s |  |  |  |  |
| Other: |  |  |  |  |
| Other: |  |  |  |  |

**Past Psychiatric Medications:** please check past medications and indicate the details below.

**Antidepressants**

Prozac (fluoxetine) - Zoloft (sertraline) - Luvox (fluvoxamine) - Paxil (paroxetine) - Celexa (citalopram) –

Lexapro (escitalopram) - Effexor (venlafaxine) - Cymbalta (duloxetine) - Wellbutrin (bupropion) - Remeron (mirtazapine) – Vybrid (vilazodone ) – Parnate (trancypromine) – Emsam (selegiline) - Serzone (nefazodone) –

Anafranil (clomipramine) - Pamelor (nortrptyline) - Tofranil (imipramine) - Elavil (amitriptyline) - Deplin (methyfolate)

**Mood Stabilizers**

Tegretol (carbamazepine) - Lithium - Depakote (valproate) - Lamictal (lamotrigine) - Tegretol (carbamazepine) – Trileptal (oxcarbamazipine) - Topamax (topiramate)

**Antipsychotics/Mood Stabilizers**

Seroquel (quetiapine) - Zyprexa (olanzepine) - Geodon (ziprasidone) - Abilify (aripiprazole) - Clozaril (clozapine) – Fanapt (iloperidone) – Saphris (asenapine) – Latuda (lurasidone) – Invega (paliperidone) - Haldol (haloperidol) - Prolixin (fluphenazine)

**Sedative/Hypnotics and Anti-anxiety**

Ambien (zolpidem) – Lunesta (eszolpiclone) - Sonata (zaleplon) - Rozerem (ramelteon) - Restoril (temazepam) - Desyrel (trazodone) - Xanax (alprazolam) - Ativan (lorazepam) - Klonopin (clonazepam) - Valium (diazepam) - Buspar (buspirone)

**ADHD medications**

Adderall (amphetamine) – Vyvanse (lisdexamphetamine) - Concerta (methylphenidate) - Ritalin (methylphenidate) - Strattera (atomoxetine) - Selegiline

|  |  |  |  |
| --- | --- | --- | --- |
| Past Medication | Dosage | Effects / Response | Side Effects |
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**Has any family member been treated with psychiatric medications?** Y  N

Details:

**MEDICAL HISTORY**

**Approximate Date and place of last physical exam**:

**All current MEDICATIONS (Prescription and OTC):**

|  |  |  |  |
| --- | --- | --- | --- |
| Medication Name | Dosage | Directions | Side Effects |
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**All current SUPPLEMENTS, HERBS or NUTRIENTS:**

|  |  |  |  |
| --- | --- | --- | --- |
| Supplement Name | Dosage | Directions | Effects and Side Effects |
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**Current and Past MEDICAL CONDITIONS and SURGERIES:**

|  |  |  |  |
| --- | --- | --- | --- |
| Medical Condition | Current | | For How Long? Details. |
| Y | N |
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**Have you ever had an EKG**? Y  N  If yes, when?

Why?       Was the EKG:  Normal  Abnormal  Unknown**?**

**Have you ever had an MRI or CAT Scan**? Y  N  If yes, when?

Why?       Was the scan  Normal  Abnormal  Unknown**?**

**Your Exercise Level:**

Do you exercise regularly? Y  N

How many days a week do you get exercise?

What kind of exercise do you get?

Do you feel better with exercise? Y  N

Do you feel “wiped out” or recover very slowly with exercise? Y  N

**Diet:**

Do you eat meat?Y  N  Vegan? Y  N  Vegetarian Y  N  Organic? Y  N

How many servings of Vegetables       and Fruits       do you get on average every day?

How many caffeinated beverages do you drink a day?Coffee       Sodas       Tea

**Tobacco History:**

Have you smoked cigarettes regularly? Y  N  Currently? Y  N

Packs per day on average?       How many years?       When did you quit?

Use pipe, cigars, or chewing tobacco currently? Y  N

What kind?       How often per day on average?       How many years?

**For Women Only:**

Are you currently pregnant or do you think you might be pregnant? Y  N

Are you planning to be pregnant soon? Y  N  Birth control method:

How many times have you been pregnant?       How many live births?

Is menstrual cycle irregular? Y  N  Details:

Is your menstrual cycle regular without birth control pills? Y  N

What is your Pattern? Every       days, Light  Medium  Heavy , lasting       days.

Do your Mood Symptoms worsen at a specific time in your cycle? Y  N  Details:

**Were there any complications during your birth or your mother’s pregnancy?**

Details:

**Describe your SLEEP patterns**:

Do you ever get night sweats? Y  N  Do you wake up with a pounding heart? Y  N

Has anything bad happened in the past while you were sleeping? Y  N

How many hours before bedtime do you eat?       Are your legs uncomfortable in bed? Y  N

Do you stop breathing while you sleep?  Y  N  Do you ever wake up gasping for breath? Y  N

Can you breathe easily through your nose? Y  N  Do you “walk off” leg discomfort at bed? Y  N

If you didn’t need to get up at a specific time would you start going to bed later and later? Y  N

Do you resist falling asleep only to get a “second wind” . . . that you are no longer tired? Y  N

How long does it take to feel awake in the morning?

Do you feel in the morning as if you were barely asleep the whole night? Y  N

**Substance Use:**

Are you now or have you been sober in the past? Y  N

Details:

Have you ever been treated for alcohol or drug use or abuse (Rehab)? Y  N

How many days per week do you drink alcohol?

What is the least number of drinks you will drink in a day?       The most?

Consequences?  Blackouts  Withdrawal  DUI  Relationship  Job  Health

Have you ever felt you ought to cut down on your drinking or drug use? Y  N

Have people annoyed you by criticizing your drinking or drug use? Y  N

Have you ever felt bad or guilty about your drinking or drug use? Y  N

Do you drink or used drugs in the morning to steady your nerves? Y  N

Do you think you may have a problem with alcohol or drug use? Y  N

Is Marijuana a problem for you? Y  N

**Circle if you have ever used or had trouble with, or simply want to discuss any of the following:**

Methamphetamine  Cocaine  Stimulants (pills)  Heroin  Pain killers

Vicodin  Methadone  Oxycontin  LSD  Mushrooms

Ecstasy  Ketamine  Marijuana  Tranquilizers  Sleeping pills

Other – Details:

Have any specific drugs made you feel better? Details:

Have any specific drugs made you feel worse? Details:

**MEDICAL CHECKLIST / REVIEW OF SYSTEMS**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Condition | You | | Family Member? | Condition | You | | Family Member? |
| Now | Past | Now | Past |
| Anemia |  |  |  | Cancer: |  |  |  |
| Low B12 |  |  |  | Cancer: |  |  |  |
| Low Iron |  |  |  | Low Cholesterol |  |  |  |
| Chronic Fatigue |  |  |  | High Cholesterol |  |  |  |
| Dizzy when Standing |  |  |  | Obesity/Overweight |  |  |  |
| Blood Sugar Lows |  |  |  | Weight Loss |  |  |  |
| Trouble Waking in Morn |  |  |  | Heart Disease |  |  |  |
| Poor exercise tolerance |  |  |  | Heart Attack/MI |  |  |  |
| Energy Peaks in Eve |  |  |  | High blood pressure |  |  |  |
| Hives |  |  |  | Chest Pain |  |  |  |
| Skin Itching |  |  |  | Palpitations |  |  |  |
| Eczema |  |  |  | Heart Attack |  |  |  |
| Psoriasis |  |  |  | Irregular Heartbeat |  |  |  |
| Fibromyalgia |  |  |  | Hemophilia |  |  |  |
| Non-restful sleep |  |  |  | Easy Bruising |  |  |  |
| Restless legs at Sleep |  |  |  | Liver Disease |  |  |  |
| Aching Legs at Rest |  |  |  | Thyroid Disease |  |  |  |
| Ulcers / Gastritic |  |  |  | Sig weight gain |  |  |  |
| Acid Reflux |  |  |  | Tendency to be cold |  |  |  |
| Constipation |  |  |  | Sleep Apnea |  |  |  |
| Diarrhea |  |  |  | Sleep Attacks in Day |  |  |  |
| Bloating |  |  |  | Daytime Sleepiness |  |  |  |
| Migraines |  |  |  | Diabetes |  |  |  |
| Food Allergies |  |  |  | Frequesnt Urination |  |  |  |
| Frequent Antibiotics |  |  |  | Chronic Pain |  |  |  |
| Sinusitis |  |  |  | Epilepsy/Seizures |  |  |  |
| Frequent UTIs |  |  |  | Head trauma/injury |  |  |  |
| Frequent Yeast Infxns |  |  |  | Polycystic Ovaries |  |  |  |
| Asthma/Respiratory |  |  |  | Irregular Period |  |  |  |
| Easily get Colds |  |  |  | Significant Weight Flux |  |  |  |
| Frequent Strep Throat |  |  |  | Hair on chin (women) |  |  |  |
| Serious Infection |  |  |  | Kidney Disease |  |  |  |
| Mono/EpsteinBarr Virus |  |  |  | Pain with Urination |  |  |  |
| Weight Loss |  |  |  | Difficulty Urinating |  |  |  |
| Unexplained Fevers |  |  |  | Pain with Orgasm |  |  |  |
| Diabetes |  |  |  | Frequent Waking to Pee |  |  |  |
| Excessive Thirst |  |  |  | Other: |  |  |  |
| Other: |  |  |  | Other: |  |  |  |
| Other: |  |  |  | Other: |  |  |  |
| Other: |  |  |  | Other: |  |  |  |
| Other: |  |  |  | Other: |  |  |  |

Details (if not explained elsewhere):

**FAMILY BACKGROUND and CHILDHOOD HISTORY**

**Background:** Were you adopted? Y  N

Where did you grow up?

List your siblings and their ages:

Father’s occupation?       Mother’s Occupation?       Did your parents’ divorce? Y  N  If so, how old were you when they divorced?

Describe your father and your relationship with him:

Describe your mother and your relationship with her:

**Trauma History:**

Do you have a history of being abused emotionally, sexually, physically or by neglect? Y  N

Details (if you are comfortable writing . . . or can discuss in office):

**Educational History:**

Did you attend college? Y  N  Where?       Major?

What is your highest educational level or degree attained?

**Occupational History:**

Are you currently:  Working  Not working by choice  Unemployed  Disabled  Retired

How long in present position?

What is/was your occupation?

Are you happy with your work?

**Relationship History and Current Family:**

Are you currently:  Married  Divorced  Single  Widowed Details:

If not married, are you currently in a relationship? Y  N  How long?

Are you sexually active? Y  N

How would you identify your sexual orientation? straight/heterosexual lesbian/gay/homosexual

bisexual transsexual unsure/questioning asexual other prefer not to answer

What is your spouse or significant other’s occupation?

Describe your relationship with your spouse or significant other:

Have you had any prior marriages? Y  N  If so, how many?

Describe any details regaring your marriage that are relevant:

Children? Y  N  How many?       What are their ages?

Describe your relationship with your children:

**Legal:** Have you ever been arrested? Y  N

Do you have any pending legal problems? Y  N  Details:

**Spiritual life:** Do you belong to a religion or spiritual group? Y  N  Which?

Have you ever had experiences of “Awe” or “Transcendence”? Y  N

Details:

**Is there anything else that you would like your doctor to know?**

**Emotional Distress – Anxiety – Short Form 8a**

PROMIS Item Bank v1.0 – Emotional Distress – Anxiety – Short Form 8a

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Page 1 of 1

**Please respond to each question or statement by marking one box per row.**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **In the past 7 days…** | | **Never** | **Rarely** | **Sometimes** | **Often** | **Always** |
| EDANX01  1 | I felt fearful | 1 | 2 | 3 | 4 | 5 |
| EDANX40  2 | I found it hard to focus on anything other than my anxiety | 1 | 2 | 3 | 4 | 5 |
| EDANX41  3 | My worries overwhelmed me | 1 | 2 | 3 | 4 | 5 |
| EDANX53  4 | I felt uneasy | 1 | 2 | 3 | 4 | 5 |
| EDANX46  5 | I felt nervous | 1 | 2 | 3 | 4 | 5 |
| EDANX07  6 | I felt like I needed help for my anxiety | 1 | 2 | 3 | 4 | 5 |
| EDANX05  7 | I felt anxious | 1 | 2 | 3 | 4 | 5 |
| EDANX54  8 | I felt tense | 1 | 2 | 3 | 4 | 5 |

**Emotional Distress – Depression – Short Form 8a**

PROMIS Item Bank v1.0 – Emotional Distress – Depression–Short Form 8a

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Page 1 of 1

**Please respond to each question or statement by marking one box per row.**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **In the past 7 days…** | | **Never** | **Rarely** | **Sometimes** | **Often** | **Always** |
| EDDEP04  1 | I felt worthless | 1 | 2 | 3 | 4 | 5 |
| EDDEP06  2 | I felt helpless | 1 | 2 | 3 | 4 | 5 |
| EDDEP29  3 | I felt depressed | 1 | 2 | 3 | 4 | 5 |
| EDDEP41  4 | I felt hopeless | 1 | 2 | 3 | 4 | 5 |
| EDDEP22  5 | I felt like a failure | 1 | 2 | 3 | 4 | 5 |
| EDDEP36  6 | I felt unhappy | 1 | 2 | 3 | 4 | 5 |
| EDDEP05  7 | I felt that I had nothing to look forward to | 1 | 2 | 3 | 4 | 5 |
| EDDEP09  8 | I felt that nothing could cheer me up | 1 | 2 | 3 | 4 | 5 |

**Fatigue – Short Form 8a**

PROMIS Item Bank v1.0 – Fatigue – Short Form 8a

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Page 1 of 1

**Please respond to each question or statement by marking one box per row.**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **During the past 7 days…** | | | **Not at all** | **A little bit** | **Somewhat** | **Quite a bit** | **Very much** |
| HI7  1 | | I feel fatigued | 1 | 2 | 3 | 4 | 5 |
| AN3  2 | | I have trouble starting things because I am tired | 1 | 2 | 3 | 4 | 5 |
| **In the past 7 days…** | | | | | | | |
| FATEXP41  3 | | How run-down did you feel on average? ... | 1 | 2 | 3 | 4 | 5 | |
| FATEXP40  4 | | How fatigued were you on average? | 1 | 2 | 3 | 4 | 5 | |
| FATEXP35  5 | | How much were you bothered by your fatigue on average? | 1 | 2 | 3 | 4 | 5 | |
| FATIMP49  6 | | To what degree did your fatigue interfere with your physical functioning? | 1 | 2 | 3 | 4 | 5 | |
| **In the past 7 days…** | | | **Never** | **Rarely** | **Sometimes** | **Often** | **Always** |
| FATIMP3  7 | How often did you have to push yourself to get things done because of your fatigue? | | 1 | 2 | 3 | 4 | 5 |
| FATIMP16  8 | How often did you have trouble finishing things because of your fatigue? | | 1 | 2 | 3 | 4 | 5 |

**Sleep Disturbance – Short Form 8a**

PROMIS Item Bank v1.0 – Sleep Disturbance – Short Form 8a

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Page 1 of 1

**Please respond to each question or statement by marking one box per row.**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **In the past 7 days…** | | **Very poor** | **Poor** | **Fair** | **Good** | **Very good** |
| Sleep109  1 | My sleep quality was | 5 | 4 | 3 | 2 | 1 |
| **In the past 7 days…** | | **Not at all** | **A little bit** | **Somewhat** | **Quite a bit** | **Very much** |
| Sleep116  2 | My sleep was refreshing. | 5 | 4 | 3 | 2 | 1 |
| Sleep20  3 | I had a problem with my sleep | 1 | 2 | 3 | 4 | 5 |
| Sleep44  4 | I had difficulty falling asleep | 1 | 2 | 3 | 4 | 5 |
| Sleep108  5 | My sleep was restless | 1 | 2 | 3 | 4 | 5 |
| Sleep72  6 | I tried hard to get to sleep | 1 | 2 | 3 | 4 | 5 |
| Sleep67  7 | I worried about not being able to fall asleep | 1 | 2 | 3 | 4 | 5 |
| Sleep115  8 | I was satisfied with my sleep. | 5 | 4 | 3 | 2 | 1 |