

PSYCHOLOGICAL HISTORY

Background:

NAME: \_\_\_\_\_

Do you have any history of psychiatric hospitalizations?

DOB: \_\_\_\_\_

When: \_\_\_\_\_

DATE: \_\_\_\_\_

Where: \_\_\_\_\_

Do you have any previous psychiatric diagnosis?

What: \_\_\_\_\_

When: \_\_\_\_\_

What are your major life stressors?

Past: \_\_\_\_\_

Present: \_\_\_\_\_

What are your major health issues?

Past: \_\_\_\_\_

Present: \_\_\_\_\_

Current State:

Please rate each of the following factors with a number correlating to the 5 point rating scale posted below.

None	Rare	Sometimes	Frequent	Constantly
1	2	3	4	5

In the past month how would I rate...

- 1. My anger \_\_\_\_\_
- 2. Anxiety \_\_\_\_\_
- 3. Depression \_\_\_\_\_
- 4. Mania \_\_\_\_\_
- 5. Suicidal thoughts \_\_\_\_\_
- 6. Homicidal thoughts \_\_\_\_\_
- 7. Physical pain \_\_\_\_\_
- 8. Addictive Behavior \_\_\_\_\_
- 9. Fatigue/Exhaustion \_\_\_\_\_
- 10. Conflict w/ \_\_\_\_\_

Family Mental Health History:

In the section below, identify if there is a family history of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.)

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes/no	_____
Anger	yes/no	_____
Anxiety	yes/no	_____
Depression	yes/no	_____
Domestic Violence	yes/no	_____
Eating Disorders	yes/no	_____
Obesity	yes/no	_____
Obsessive Compulsive Behavior	yes/no	_____
Schizophrenia	yes/no	_____
Suicide Attempts	yes/no	_____

SUBSTANCE/PRESCRIPTION MEDICATION USAGE

Tobacco:

Do you use?            Yes    No

Age of first use \_\_\_\_\_

Date of last use \_\_\_\_\_

Frequency \_\_\_\_\_

Alcohol:

Do you use?            Yes    No

Age of first use \_\_\_\_\_

Date of last use \_\_\_\_\_

Frequency \_\_\_\_\_

*Cannabis:*

Do you use?            Yes    No

Age of first use \_\_\_\_\_

Date of last use \_\_\_\_\_

Frequency \_\_\_\_\_

*Stimulants:*

Do you use?            Yes    No

Age of first use \_\_\_\_\_

Date of last use \_\_\_\_\_

Frequency \_\_\_\_\_

*Hallucinogens:*

Do you use?            Yes    No

Age of first use \_\_\_\_\_

Date of last use \_\_\_\_\_

Frequency \_\_\_\_\_

*Non-prescribed Medications:*

Do you use?            Yes    No

Age of first use \_\_\_\_\_

Date of last use \_\_\_\_\_

Frequency \_\_\_\_\_

*Other:*

Do you use?            Yes    No

Age of first use \_\_\_\_\_

Date of last use \_\_\_\_\_

Frequency \_\_\_\_\_

*Current Prescribed Psychiatric Medications:*

<i>Name</i>	<i>Dosage</i>	<i>Usage</i>	<i>Side Effects</i>
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

*Past Prescribed Psychiatric Medications* \_\_\_\_\_