PSYCHOLOGICAL HISTORY

Background:

NAME:_____
DOB:_____
DATE:_____

Do you have any history of psychiatric hospitalizations?
When:_____
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 ___
   Type_____ ___
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:

Name	*Dosage*	*Usage*	*Side Effects*

Past Prescribed Psychiatric *Medications*_____