Clinical History Form

Patient First Name: _____ Patient Last Name: _____

Date Completed: _____ Patient Date of Birth: _____

Primary Care Physician: _____ Who referred you: _____

Why are you being seen: _____

How long has this been a problem: _____

Have you ever been treated for any of the following:

☐ Depression	☐ ADHD	☐ Anxiety	☐ Dementia	☐ OCD
☐ Schizophrenia	☐ Panic Attacks	☐ PTSD	☐ Alcohol Abuse	☐ Substance Abuse
☐ Insomnia	☐ Binge-eating	☐ Anorexia	☐ Bulimia	☐ Bipolar Disorder
☐ Autism	☐ Anger	☐ Oppositional defiance disorder		

Stressors

Given the list of categories below, how much stress is each area currently causing you?

	None	Mild	Moderate	Severe
Family	☐	☐	☐	☐
Friends	☐	☐	☐	☐
Relationships	☐	☐	☐	☐
Educational	☐	☐	☐	☐
Economic	☐	☐	☐	☐
Occupational	☐	☐	☐	☐
Housing	☐	☐	☐	☐
Legal	☐	☐	☐	☐
Health	☐	☐	☐	☐

Review of Systems

Look at the following list of possible physical symptoms and check off any that you have experienced in the last several days.

Constitutional

- ☐ Chronic pain
- ☐ Loss of appetite
- ☐ Unexplained weight loss
- ☐ Fatigue/lethargy
- ☐ Hot/cold sweats
- ☐ Night sweats
- ☐ Sleeping pattern disruption
- ☐ Other:

Eyes, Ears, Nose, Mouth

- ☐ Eye issues
- ☐ Blurred/double vision
- ☐ Visual change
- ☐ Sensitivity to light
- ☐ Earache
- ☐ Tinnitus
- ☐ Dry mouth
- ☐ Other:

Cardiovascular & Respiratory

- ☐ Chest pain
- ☐ Palpitations (fast heartbeat)
- ☐ Fainting spells
- ☐ Shortness of breath with exercise
- ☐ Pain with breathing
- ☐ Chronic cough
- ☐ Chronic shortness of breath
- ☐ Other:

Musculoskeletal & GI

- ☐ Swelling in joints
- ☐ Joint pain/stiffness
- ☐ Muscle pain/cramping
- ☐ Past injury to spine/joints
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Other:

Allergic & Endocrine

- ☐ Frequent infections
- ☐ Hives
- ☐ Anaphylaxis
- ☐ Cold or heat intolerance
- ☐ Excessive appetite
- ☐ Excessive thirst or urination
- ☐ Excessive sweating
- ☐ Other:

Hematologic & Genitourinary

- ☐ Blood clots
- ☐ Excessive bruising
- ☐ Loss of urine control
- ☐ Blood in urine
- ☐ Increased frequency of urination
- ☐ Urine retention
- ☐ Frequent urine infections
- ☐ Other:

Genitourinary (Women)

- ☐ Unusual vaginal discharge
- ☐ Heavy or irregular periods
- ☐ No menses (periods stopped)
- ☐ Currently pregnant
- ☐ Sterility/infertility
- ☐ Other:

Genitourinary (Men)

- ☐ Slow urine stream
- ☐ Scrotal pain
- ☐ Abnormal penis discharge
- ☐ Trouble getting erections
- ☐ Inability to orgasm
- ☐ Other:

Neurological

- ☐ Fainting spells or blackouts
- ☐ Dizziness/vertigo
- ☐ Short term memory trouble
- ☐ Memory loss
- ☐ Neuropathy
- ☐ Other:

Integumentary

- ☐ Lesions
- ☐ Unusual moles
- ☐ Easy bruising
- ☐ Rashes
- ☐ Hair loss
- ☐ Other:

Psychiatric

- ☐ Feeling depressed
- ☐ Difficulty concentrating
- ☐ Phobias/unexplained fears
- ☐ No pleasure from life anymore
- ☐ Anxiety
- ☐ Insomnia

- ☐ Excessive moodiness
- ☐ Stress
- ☐ Manic episodes
- ☐ Confusion/memory loss
- ☐ Nightmares
- ☐ Other:

Substance Use History

Use: Do you have a history of substance/drug use? If yes, please fill out table to best of your knowledge.

Substance Used	Yes	No	Age of first use	Age of last use	How was it taken:				Amount used	Days per month
Amphetamines/Speed					O Oral	O Nasal	O Inhaled	O Injected		
Barbiturates/Downers					O Oral	O Nasal	O Inhaled	O Injected		
Opiates					O Oral	O Nasal	O Inhaled	O Injected		
Cocaine					O Oral	O Nasal	O Inhaled	O Injected		
Psychedelics					O Oral	O Nasal	O Inhaled	O Injected		
Inhalants					O Oral	O Nasal	O Inhaled	O Injected		
Cannabis/Marijuana					O Oral	O Nasal	O Inhaled	O Injected		
Benzodiazepines					O Oral	O Nasal	O Inhaled	O Injected		
Alcohol					O Oral	O Nasal	O Inhaled	O Injected		
Other:					O Oral	O Nasal	O Inhaled	O Injected		

Treatment: Have you ever received treatment for substance abuse? If yes, please fill out table to best of your knowledge.

Treatment Type	Yes	No	Number of times attended	Age of first treatment	Age of last treatment	Additional information (i.e. graduated, discharged, etc.)
Inpatient						
Intensive Outpatient						
Outpatient						
12-Step Program						

Consequences: Have you experienced any of these consequences as a result of alcohol consumption or abuse of substances? (please check all that apply)

- ☐ No consequences
- ☐ Felt that you needed to cut down on drinking
- ☐ Been annoyed by others criticizing your drinking
- ☐ Felt guilty about drinking
- ☐ Needing a drink first thing in the morning
- ☐ Increased tolerance
- ☐ Withdrawal (shakes, sweating, nausea, rapid heart rate)
- ☐ Seizures
- ☐ Blackouts
- ☐ Effects on physical health
- ☐ Using/consuming more than intended
- ☐ Unintentional overdose
- ☐ DUI
- ☐ Arrests
- ☐ Physical fights or assaults
- ☐ Relationship conflicts
- ☐ Problems with money
- ☐ Job loss or problems at work/school

Psychiatric/Mental Health History

Have you been hospitalized for psychiatric/mental health treatment in the past? If yes, please describe reason for hospitalization, when hospitalization occurred, and where.

Reason Date Hospitalized Where

_____

_____

Have you seen a therapist, counselor, or psychiatrist for mental health treatment? If yes, please describe reason for treatment, when treatment occurred, and provider name.

Reason Dates of Treatment Provider Name

_____

_____

Have you ever engaged in self-harming behaviors (such as cutting or burning)? ☐ Yes ☐ No
When was the last time this occurred? _____

Have you ever attempted to kill yourself? ☐ Yes ☐ No
How many times has this occurred? _____

Have you had any history of violent behavior? ☐ Yes ☐ No

Past Medical History

Have you had a history of any of the following health problems? (Please check all that apply)

☐ No problems	☐ Gall bladder disease	☐ Kidney disease
☐ Allergies	☐ Gastritis/Ulcer	☐ Kidney stones
☐ Anemia	☐ Glaucoma	☐ Liver disease
☐ Arthritis	☐ Gout	☐ Lupus
☐ Asthma	☐ Hearing loss	☐ Migraine headaches
☐ Back Problems	☐ Heart disease	☐ Multiple sclerosis
☐ Cancer	☐ Heart defect from birth	☐ Obesity or overweight
☐ Cataracts	☐ Heart valve problems	☐ Parkinson's disease
☐ Chickenpox (as a child)	☐ Hemorrhoids	☐ Polyps
☐ Chronic bronchitis	☐ Hepatitis	☐ Sexually transmitted disease
☐ COPD (Emphysema)	☐ Hernia	☐ Seizures
☐ Diabetes	☐ HIV	☐ Sleep apnea
☐ Diverticulitis	☐ High blood pressure	☐ Stroke/TIA
☐ Fainting spells/Passing out	☐ Low blood pressure	☐ Testosterone (low)
☐ High cholesterol	☐ Inflammatory bowel disease	☐ Thyroid problems
☐ Fibromyalgia	☐ Iron deficiency	☐ Tuberculosis

Have you had a history of surgery in any of the following areas? (Please check all that apply)

☐ No surgical history	☐ Hysterectomy (Ovaries removed)	☐ Penis
☐ Back/neck	☐ Hysterectomy (Ovaries retained)	☐ Prostate
☐ Brain	☐ Intestine	☐ Sex Change
☐ Cardiac/heart	☐ Kidney	☐ Shoulder/Elbow/Wrist/Hand
☐ Ear/Nose/Throat	☐ Liver	☐ Stomach
☐ Gall Bladder	☐ Lung	☐ Tonsils
☐ Hernia	☐ Pancreas	☐ Vagina
☐ Hip/Knee/Ankle/Foot	☐ Pelvis	☐ Weight loss
Other:		

Psychiatric Medication History: Please circle and explain if you have ever taken any of the following medications.

Antidepressants	**When?**	**Dosage?**	**Did it help?**	**Side effects?**
Prozac (fluoxetine)			☐ Yes ☐ No	☐ Yes ☐ No
Zoloft (sertraline)			☐ Yes ☐ No	☐ Yes ☐ No
Luvox (fluvoxamine)			☐ Yes ☐ No	☐ Yes ☐ No
Paxil (paroxetine)			☐ Yes ☐ No	☐ Yes ☐ No
Celexa (citalopram)			☐ Yes ☐ No	☐ Yes ☐ No
Effexor (venlafaxine)			☐ Yes ☐ No	☐ Yes ☐ No
Cymbalta (duloxetine)			☐ Yes ☐ No	☐ Yes ☐ No

Wellbutrin (bupropion)			☐ Yes ☐ No	☐ Yes ☐ No
Remeron (mirtazapine)			☐ Yes ☐ No	☐ Yes ☐ No
Serzone (nefazodone)			☐ Yes ☐ No	☐ Yes ☐ No
Anafranil (clomipramine)			☐ Yes ☐ No	☐ Yes ☐ No
Pamelor (nortrptyline)			☐ Yes ☐ No	☐ Yes ☐ No
Tofranil (imipramine)			☐ Yes ☐ No	☐ Yes ☐ No
Elavil (amitriptyline)			☐ Yes ☐ No	☐ Yes ☐ No
Pristiq (desvenlafaxin)			☐ Yes ☐ No	☐ Yes ☐ No
Desyrel (trazadone)			☐ Yes ☐ No	☐ Yes ☐ No
Viibryd (vilazodone)			☐ Yes ☐ No	☐ Yes ☐ No
Adapin (doxepin)			☐ Yes ☐ No	☐ Yes ☐ No
Norpramin (desipramine)			☐ Yes ☐ No	☐ Yes ☐ No
Lexapro (escitalopram)			☐ Yes ☐ No	☐ Yes ☐ No
Fetzima			☐ Yes ☐ No	☐ Yes ☐ No
Trintellix			☐ Yes ☐ No	☐ Yes ☐ No
AntipsychoticsMood Stabilizers	**When?**	**Dosage?**	**Did it help?**	**Side effects?**
Seroquel (quetiapine)			☐ Yes ☐ No	☐ Yes ☐ No
Zyprexa (olanzapine)			☐ Yes ☐ No	☐ Yes ☐ No
Geodon (ziprasidone)			☐ Yes ☐ No	☐ Yes ☐ No
Abilify (aripiprazole)			☐ Yes ☐ No	☐ Yes ☐ No
Clozaril (clozapine)			☐ Yes ☐ No	☐ Yes ☐ No
Haldol (haloperidol)			☐ Yes ☐ No	☐ Yes ☐ No
Invega			☐ Yes ☐ No	☐ Yes ☐ No
Latuda			☐ Yes ☐ No	☐ Yes ☐ No
Risperdal			☐ Yes ☐ No	☐ Yes ☐ No
Saphris			☐ Yes ☐ No	☐ Yes ☐ No
Vraylar			☐ Yes ☐ No	☐ Yes ☐ No
Prolixin (fluphenazine)			☐ Yes ☐ No	☐ Yes ☐ No
Depakote			☐ Yes ☐ No	☐ Yes ☐ No
Lithium			☐ Yes ☐ No	☐ Yes ☐ No
Lamictal (lamotrigine)			☐ Yes ☐ No	☐ Yes ☐ No
Tegretol			☐ Yes ☐ No	☐ Yes ☐ No
Trileptal			☐ Yes ☐ No	☐ Yes ☐ No
SedativeHypnotics	**When?**	**Dosage?**	**Did it help?**	**Side effects?**
Ambien (zolpidem)			☐ Yes ☐ No	☐ Yes ☐ No
Sonata (zaleplon)			☐ Yes ☐ No	☐ Yes ☐ No
Restoril (temazepam)			☐ Yes ☐ No	☐ Yes ☐ No
Rozerem (ramelteon)			☐ Yes ☐ No	☐ Yes ☐ No
Trazodone			☐ Yes ☐ No	☐ Yes ☐ No
Lunesta			☐ Yes ☐ No	☐ Yes ☐ No
Belsomra			☐ Yes ☐ No	☐ Yes ☐ No
Melatonin			☐ Yes ☐ No	☐ Yes ☐ No
ADHD Medications	**When?**	**Dosage?**	**Did it help?**	**Side effects?**
Adderall (amphetamine)			☐ Yes ☐ No	☐ Yes ☐ No
Adderall XR			☐ Yes ☐ No	☐ Yes ☐ No
Vyvanse			☐ Yes ☐ No	☐ Yes ☐ No

Concerta (methylphenidate)			☐ Yes ☐ No	☐ Yes ☐ No
Ritalin (methylphenidate)			☐ Yes ☐ No	☐ Yes ☐ No
Focalin			☐ Yes ☐ No	☐ Yes ☐ No
Strattera			☐ Yes ☐ No	☐ Yes ☐ No
Guanfacine			☐ Yes ☐ No	☐ Yes ☐ No
Clonidine			☐ Yes ☐ No	☐ Yes ☐ No
Antianxiety Medications	**When?**	**Dosage?**	**Did it help?**	**Side effects?**
Xanax (alprazolam)			☐ Yes ☐ No	☐ Yes ☐ No
Ativan (lorazepam)			☐ Yes ☐ No	☐ Yes ☐ No
Klonopin (clonazepam)			☐ Yes ☐ No	☐ Yes ☐ No
Valium (diazepam)			☐ Yes ☐ No	☐ Yes ☐ No
Clonidine			☐ Yes ☐ No	☐ Yes ☐ No
Buspar (buspirone)			☐ Yes ☐ No	☐ Yes ☐ No
Propranolol			☐ Yes ☐ No	☐ Yes ☐ No
Neurontin (gabapentin)			☐ Yes ☐ No	☐ Yes ☐ No
Other Psychiatric Medications	**When?**	**Dosage?**	**Did it help?**	**Side effects?**
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No
			☐ Yes ☐ No	☐ Yes ☐ No

Do you have any medication allergies? If yes, please list below:

_____

_____

Are you taking any medications currently? If yes, please list below:

_____

_____

_____

Past Family Psychiatric History

Do you have any family members with a history of psychiatric illness or substance abuse/dependence (including depression, anxiety, ADHD, bipolar disorder, schizophrenia, completed suicide, etc)? If yes, please list below:

_____

_____

_____

Developmental and Educational History

During your pregnancy/birth, did your mother have any problems with any of the following:

☐ None of these
☐ Exposure to drugs or alcohol during pregnancy
☐ A difficult pregnancy
☐ Problems with delivery
☐ Other: _____

Did you have any complications after your birth? (e.g. premature birth, jaundice, breathing difficulties)?
☐ Yes ☐ No

Did you have any delays or difficulties in reaching the following developmental milestones?
☐ None of these
☐ Walking
☐ Talking
☐ Toilet training
☐ Other: _____
☐ Sleeping alone
☐ Being away from parents
☐ Making friends

Which options below best describe your childhood home atmosphere?
☐ Normal
☐ Supportive
☐ Parental fighting
☐ Other: _____
☐ Parental violence
☐ Financial difficulties
☐ Frequent moving

Which of the following challenges were experienced during your childhood?
☐ None of these
☐ Tantrums
☐ Enuresis (bed wetting)
☐ Encopresis (fecal incontinence)
☐ Running away from home
☐ Fighting
☐ Stealing
☐ Property damage
☐ Fire setting
☐ Animal cruelty
☐ Separation anxiety
☐ Victim of bullying
☐ Engaged in bullying
☐ Depression
☐ Death of a parent/caregiver
☐ Parental divorce

Which of the following best describe problems you may have had in school?
☐ None of these
☐ Fighting
☐ School phobia
☐ Truancy
☐ Detentions
☐ Suspensions
☐ Expulsions
☐ School refusal
☐ Class failures
☐ Repetition of grades
☐ Special education
☐ Remedial classes

Did you have additional schooling outside of the standard classroom setting? (please check all that apply)
☐ None of these
☐ Speech classes
☐ Tutoring
☐ Accommodations

What is your highest level of education?
☐ Less than high school
☐ High school/GED
☐ Some college
☐ Two-year degree
☐ Four-year degree
☐ Graduate/professional degree

If currently enrolled in school, please list current school and grade:

General Social History

Which options below best describes your social situation?

☐ Supportive social network
☐ Few friends
☐ Substance-use based friends
☐ Other: _____

☐ No friends
☐ Distant from family of origin
☐ Family conflict

What is your current marital status?
☐ Single
☐ Never married
☐ Married/Permanent partnership
☐ Divorced
☐ Separated or divorce in process
☐ Widowed

What is the satisfaction level of your intimate relationship?
☐ Very satisfied
☐ Satisfied
☐ Somewhat satisfied
☐ Dissatisfied
☐ Not applicable

What is your sexual orientation?
☐ Heterosexual
☐ Homosexual
☐ Bisexual

What is your current living situation?
☐ Rent (apartment/house)
☐ Own (house/condo)
☐ Group Home
☐ Homeless
☐ Foster care
☐ Nursing home/Assisted living

Who do you currently live with? (Please check all that apply)
☐ Live alone
☐ Roommates
☐ Partner/Spouse
☐ Other: _____
☐ Parent(s)
☐ Sibling(s)
☐ Children

Do you currently participate in spiritual activities? ☐ Yes ☐ No

What is your current occupation status?
☐ Employed full-time
☐ Employed part-time
☐ Temporary/seasonal employment
☐ Full-time student
☐ Part-time student
☐ Homemaker
☐ Unemployed (seeking work)
☐ Unemployed (not seeking work)
☐ Retired
☐ Disability

Have you ever been in the military? ☐ Yes ☐ No

Have you ever been a victim of emotional/verbal abuse? ☐ Yes ☐ No

Have you ever been a victim of physical abuse? ☐ Yes ☐ No

Have you ever been a victim of sexual abuse? ☐ Yes ☐ No

What are your hobbies/interests? _____

Do you smoke cigarettes or use any other forms of tobacco? ☐ Yes ☐ No

Have you ever been in trouble with the law? ☐ Yes ☐ No

Menstruation and Pregnancy History

At what age did you begin menstruation? _____

Which of these bests describe your premenstrual symptoms?

☐ None of these
☐ Dysphoria
☐ Cramps
☐ Appetite change
☐ Bloating
☐ Sleep disturbance

Have you ever been pregnant? ☐ Yes ☐ No If YES, how many times? _____

Have you ever given birth? ☐ Yes ☐ No

If YES, children ages? _____

Have you ever had miscarriage(s)? ☐ Yes ☐ No

Please answer "Yes" to any of the below questions that apply.

	Yes
Sad or depressed mood	
Withdrawn from family or friends	
Loss of interest in activities or hobbies	
Feelings of guilt or worthlessness	
Feeling hopeless about the future	
Sleep disturbance	
Change in appetite	
Low energy or fatigue	
Trouble focusing or concentrating	
Thoughts of hurting self	
Thoughts of suicide	
Thoughts of hurting or killing others	
Irritability	
Severe angry outbursts (verbal or physical)	
Worrying too much	
Feeling or acting restless	
Muscle tension	
Panic or anxiety attacks	
Fear of looking stupid or being embarrassed	
Fear of offending others	
Any other fears or phobias	
Drastic mood swings	
Episodes of decreased need for sleep	
Extreme hyperactivity	
Racing thoughts	
Talking so fast it's hard to understand	
Overly happy or euphoric	
Overly confident	
Obsessive thoughts, feelings, or images in mind	
Habits that you feel you must do, even if it doesn't make sense	
Poor body image	
Trying to lose weight even though he/she is not overweight	
Intentionally throwing up after eating	

	Yes
Upsetting or intrusive memories	
Nightmares	
Flashbacks (feeling or acting like the event is happening again)	
Avoiding talking or thinking about what happened	
Feeling upset by reminders of the event	
Difficulty wrapping up final details of a project	
Difficulty getting things in order or organized for a task	
Difficulty remembering appointments or obligations	
Procrastinating or delaying starting a project	
Fidgeting or squirming with hands or feet	
Feeling overly active and compelled to do things	
Easily loses temper	
Easily annoyed	
Defiant	
Argues with authority figures	
Annoying others on purpose	
Blaming others for his/her mistakes	
Resentful, spiteful or vindictive	
Lying	
Stealing	
Destroying property	
Setting fires	
Skipping school (if applicable)	
Hurting other people or animals	
Difficulty learning	
Trouble understanding social cues	
Difficulty forming or keeping friendships	
Being very sensitive to sound, light, touch or smell	
Tics, twitches or involuntary movements	
Making involuntary sounds	