Patient Information

Patient Name: _____ _____ _____
Last First Middle Initial

Prior Last Name: _____ Race: Select

Social Security Number: _____ - _____ - _____ Date of Birth: *(mm/dd/yyyy)*

Sex: Select Mailing Address: _____

Marital Status: Select City / State / Zip: _____

Phone Number: _____ Other Number: _____

Emergency Contact Information

Contact Name: _____ _____ _____
Last First Middle Initial

Mailing Address: _____

City / State / Zip: _____

Phone Number: _____ Other Number: _____

Relationship to Patient: _____

Protected Health Information

For confidentiality reasons, family member phone calls about sessions will not be returned. I must request my family and or specified individual to join me as part of my appointment if I wish to include them in my session. I know and agree to the charges provided to me by AbidingHelp if they join me during my appointment.

Therefore I,_____, give AbidingHelp permission to make and disclose the following with the person listed below.

☐ Scheduling / Canceling appointments

☐ Medication questions

Name: _____ Phone: _____

Relation: _____

Source of stress - Select All that apply

☐ Health	☐ Family	☐ Finance
☐ Work	☐ Relationships	☐ Lost
☐ School	☐ Physical Appearance / Body Image	☐ Housing

Other: _____

Psychiatric History

Yes	No	
☐	☐	Have you ever been evaluated by a psychiatrist before?
☐	☐	Have you ever been in psychotherapy (talk therapy) before?
☐	☐	Have you ever been hospitalized on a psychiatric unit?
☐	☐	Have you ever attempted to end your life?
☐	☐	Have you ever been aggressive or violent towards others?
☐	☐	Have you ever been treated for an alcohol or drug abuse problem?
☐	☐	Have you ever been prescribed medication for a mental health condition?
☐	☐	Does any family member have a mental illness?

(If yes, please specify relative in the space provided)

☐ Bipolar disorder	☐ Post-traumatic Stress disorder
☐ Major depression	☐ Schizophrenia
☐ Anxiety disorder	☐ ADHD
☐ Panic disorder	☐ Drug / Alcohol dependence
☐ Obsessive Compulive Disorder (OCD)	

Current Medication and Allergies:

1. What daily / weekly medications are you currently taking?

   _____

2. Have you or are you currently taking any psych medication?

   _____

3. Do you have allergies to medication? *(if "Yes" please list below)*

   _____

Current Concerns - Please **CHECK** all that apply

- ☐ Anxiety/Worry/Nervousness
- ☐ Sadness/Depression
- ☐ Anger/Temper
- ☐ Irritability
- ☐ Sleep difficulty
- ☐ Change in appetite/weight
- ☐ Loss of pleasure in activities
- ☐ Concentration difficulties
- ☐ Memory lapses
- ☐ Low motivation
- ☐ Mood Swings
- ☐ Impulsivity
- ☐ Nightmares
- ☐ Binge eating
- ☐ Thoughts of harming yourself
- ☐ Thoughts of harming others
- ☐ Low self-esteem
- ☐ Paranoia/Suspiciousness
- ☐ Hearing voices/noises
- ☐ Seeing visions
- ☐ Panic attacks
- ☐ Racing thoughts
- ☐ Recurring, unwanted thoughts
- ☐ Alcohol or other substance use
- ☐ Loneliness
- ☐ Risk-taking behavior
- ☐ Flashbacks
- ☐ Restrictive eating

Other: _____

Alcohol History:

1. How many drinks can you consume before feeling intoxicated? _____
2. Have you ever felt that you should cut down drinking? ☐Yes ☐No
3. Have close friends or family members ever told you about things you said or did while you were drinking that you could not remember? ☐ Yes ☐N o
4. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? ☐ Yes ☐No
5. Have you ever had a DWI/DUI? ☐ Yes ☐ No

Suicide Risk Assessment:

Have you ever had feelings or thoughts that you didn't want to live? ☐Yes ☐No

If YES, please check and answer the following. If NO, please skip.

- Do you currently feel that you do not want to live? ☐ Yes ☐ No
- How often do you have these thoughts? _____
- When was the first time you had thoughts of dying? _____
- Has anything happened recently to make you feel this way? _____
- On a scale of 1-10 (10 being the strongest) how strong is the desire to end your life currently? _____
- Would anything make it better? _____
- Have you ever thought about how you would end your life? _____
- Is the method you would use readily available? _____
- Have you planned a time for this? _____
- Is there anything that will stop you from ending your own life? _____
- Do you feel hopeless and/or worthless? _____
- Have you ever tried to kill or harm yourself before? _____

Psychosocial History:

1. Place of birth: _____
2. Any history of birth complications or developmental delays? ☐Yes ☐No
   If YES, please specify: _____
3. My childhood was (please select) Select
4. History of abuse (please select) None
5. With whom do you live? _____
6. Do you have any children? ☐Yes ☐No (If yes, list ages) _____
7. Religion/Spiritual beliefs: _____
8. Military service: _____
9. Occupation: _____
10. Past employment: _____
11. Highest level of education: _____
12. History of arrests or other legal issues? _____

Substance Use History: Please **SELECT** all that apply

Caffeine	○	○	○
Alcohol	○	○	○
Nicotine	○	○	○
Marijuana	○	○	○
Cocaine	○	○	○
Amphetamines/Stimulants	○	○	○
Hallucinogens (PCP, LSD, Mushrooms)	○	○	○
Opiates (Heroin, Oxycodone)	○	○	○
Sedatives (Valium, Xanax)	○	○	○

Patient Health Questionnaire

Name: _____ Date: _____

Over the last 2 weeks, how often have you been bothered by any of th following problems?

	Not at all	Several Days	More than half the days	Nearly everyday
1. Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless	☐	☐	☐	☐
3. Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4. Feeling Tired or having little energy	☐	☐	☐	☐
5. Poor appetite or over eating	☐	☐	☐	☐
6. Feeling bad about yourself or that you are failing or have let you or your family down	☐	☐	☐	☐
7. Trouble concentrating on things such as reading the newspaper or watching television	☐	☐	☐	☐
8. Moving or speaking so slowly that other people could have noticed or the opposite being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
9. Thoughts that you would be better off dead or hurting yourself	☐	☐	☐	☐

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

☐ I verify that all the information provided on this form is complete and accurate to the best of my knowledge.

x _____
Signature

_____
Date | *mm/dd/yyyy*