



<p><b>Psych History:</b></p> <p>Individual Therapy:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Couples Therapy:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Family Therapy:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Psychiatric History:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
<p>Diagnosis Known:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>History of suicidal thoughts?:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>History of suicidal attempts?:</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Psychiatric ER Visit:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Psychiatric Hospitalization:</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Family Psychological or Psychiatric History:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
<p><b>Medical History:</b></p> <p>PCP Name:</p> <p>_____</p> <p>PCP Number:</p> <p>_____</p> <p>Last PCP visit:</p> <p>_____</p> <p>Results of exam</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Medical Concerns:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Major Illnesses:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Medical Hospitalizations:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
<p>Surgeries:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Medical Challenges:</p> <p><input type="checkbox"/> Sleep Problems</p> <p>_____</p> <p>_____</p> <p><input type="checkbox"/> Eating Problems</p> <p>_____</p> <p>_____</p>	<p>Specialists:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Family Medical History:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>

<p>Current Medication:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Dosage:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Times Per Day:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>For Treatment of:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
<p>Legal History:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>History of Abuse?:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Describe your social network/support:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Describe your present religious affiliation:</p> <p>_____</p> <p>_____</p> <p>Is this important to you?: _____</p> <p>_____</p>
<p>What are the reason(s) for your visit?:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>How long has this problem persisted?:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Under what conditions do your problems usually get worse?:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Under what conditions are your problems usually improved?:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
<p>What are your therapy goals?:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>What are your expectations?:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>What are your strengths?:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>What are your weaknesses?:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>

<i>Life is hopeless</i>	<i>I am lonely</i>	<i>I am a failure</i>	<i>I am not liked</i>
<input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Sometimes <input type="checkbox"/> Frequently	<input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Sometimes <input type="checkbox"/> Frequently	<input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Sometimes <input type="checkbox"/> Frequently	<input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Sometimes <input type="checkbox"/> Frequently
<i>I want to die</i>	<i>I want to hurt so</i>	<i>I am so stupid</i>	<i>I feel worthless</i>
<input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Sometimes <input type="checkbox"/> Frequently	<input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Sometimes <input type="checkbox"/> Frequently	<input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Sometimes <input type="checkbox"/> Frequently	<input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Sometimes <input type="checkbox"/> Frequently
<i>I tire quickly</i>	<i>I feel fearful</i>	<i>I feel irritated</i>	<i>I have no interest</i>
<input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Sometimes <input type="checkbox"/> Frequently	<input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Sometimes <input type="checkbox"/> Frequently	<input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Sometimes <input type="checkbox"/> Frequently	<input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Sometimes <input type="checkbox"/> Frequently
<i>Getting lost or confused</i>	<i>Hearing voices</i>	<i>I feel loved and wanted</i>	<i>Problems with my memory</i>
<input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Sometimes <input type="checkbox"/> Frequently	<input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Sometimes <input type="checkbox"/> Frequently	<input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Sometimes <input type="checkbox"/> Frequently	<input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Sometimes <input type="checkbox"/> Frequently
<i>I have an upset stomach</i>	<i>I have headaches</i>	<i>I feel blue</i>	<i>I have sore muscles</i>
<input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Sometimes <input type="checkbox"/> Frequently	<input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Sometimes <input type="checkbox"/> Frequently	<input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Sometimes <input type="checkbox"/> Frequently	<input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Sometimes <input type="checkbox"/> Frequently
<i>I am out of control</i>	<i>I have no emotions</i>	<i>I can't concentrate</i>	<i>Someone is watching me</i>
<input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Sometimes <input type="checkbox"/> Frequently	<input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Sometimes <input type="checkbox"/> Frequently	<input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Sometimes <input type="checkbox"/> Frequently	<input type="checkbox"/> Never <input type="checkbox"/> Rarely <input type="checkbox"/> Sometimes <input type="checkbox"/> Frequently

