Patient Name: ___________________________________
Date of Birth: ___________________________________

| DEMOGRAPHIC INFORMATION | | |
|---|---|---|
| Patient's Legal Name: | | Social Security #: |
| Gender: | Age: | Date of Birth: |
| Address: | | |
| City, State, ZIP: | | |
| Primary Phone: [ ] OK to leave message | | Alternate Phone: [ ] OK to leave message |
| Email Address: | | |
| Marital Status:<br>[ ] Single [ ] Married / Domestic Partner [ ] Divorced [ ] Separated [ ] Widowed | | |
| Emergency Contact: | | Relationship to Patient: |
| Phone: | Would you like a therapy dog present during your sessions?<br>[ ] Yes [ ] No [ ] I'm allergic to dogs | |

| EMPLOYMENT & INSURANCE | |
|---|---|
| Employment Status:<br>[ ] Full-Time [ ] Part-Time [ ] Retired [ ] Disability [ ] Student [ ] None | |
| Employer Name: | Occupation: |
| Employer Address: | |
| City, State, ZIP: | |
| Insurance Policy Holder Name: | Policy Holder's Date of Birth: |
| Insurance Company: | |
| Member ID: | Group Number: |

*(Continued on next page)*

Patient Name: ___________________________________
Date of Birth: ___________________________________

| RESPONSIBLE PARTY INFORMATION | | |
|---|---|---|
| *Only complete this section if the responsible party is other than the patient.* | | |
| Name of Responsible Party: | Relationship to Patient: | |
| Address: | | |
| City, State, ZIP: | | |
| Home Phone: | Work Phone: | Cell Phone: |
| Social Security #: | Employer's Name: | |
| Employer's Address: | | |
| City, State, ZIP: | | |

| CURRENT HOUSEHOLD SITUATION | | |
|---|---|---|
| *Please complete one line for each person living in your household.* | | |
| Name: | Relationship to Patient: | Age: |
| Name: | Relationship to Patient: | Age: |
| Name: | Relationship to Patient: | Age: |
| Name: | Relationship to Patient: | Age: |
| Name: | Relationship to Patient: | Age: |
| Name: | Relationship to Patient: | Age: |
| Name: | Relationship to Patient: | Age: |

*(Continued on next page)*

Patient Name: ______________________________
Date of Birth: ______________________________

| REASON FOR YOUR VISIT/CONCERNS |
| --- |
| Please list the reason for your visit: |

| PAST MEDICAL HISTORY | | |
| --- | --- | --- |
| Have you ever been seen by a Psychiatrist or Therapist before:<br>*If yes, please list names and dates seen:* | [ ] Yes | [ ] No |
| Have you ever been hospitalized for mental health reasons:<br>*If yes, please list where hospitalized and dates:* | [ ] Yes | [ ] No |
| Have you ever attempted to end your life: | [ ] Yes | [ ] No |

Physical health history (please check all that apply):

| | | |
| --- | --- | --- |
| [ ] Anemia | [ ] Hepatitis | [ ] Migraine Headaches |
| [ ] Asthma | [ ] High Blood Pressure | [ ] Seizure Disorder |
| [ ] Cancer | [ ] High Cholesterol | [ ] Sleep Apnea |
| [ ] Diabetes | [ ] HIV / AIDS | [ ] Stroke |
| [ ] Fibromyalgia | [ ] Irritable Bowel Syndrome | [ ] Thyroid Disease |
| [ ] GERD (Reflux) | [ ] Kidney Disease | [ ] Traumatic Brain Injury |
| [ ] Heart Disease | [ ] Low Testosterone | [ ] Urinary Tract Infection |

Other health conditions not specified above:

Please list any allergies to medications:

*(Continued on next page)*

Adelpha Psychiatric Group

Patient Name: ___________________________________
Date of Birth: ___________________________________

| PRENATAL HISTORY | | |
|---|---|---|
| *Only complete this section if the patient is under 16 years old.* | | |
| Were there any complications during pregnancy? | [ ] Yes [ ] No | If yes, please list the complications: |
| Were any substances ingested during pregnancy (illicit, tobacco, alcohol, AED, lithium, etch.)? | [ ] Yes [ ] No | If yes, please list the substances: |
| Were there any complications during birth? | [ ] Yes [ ] No | If yes, please list the complications: |
| What was the child's gestational age at delivery? | | |
| What was the child's birth weight? | | |
| What was the mode of delivery? | | |

## DEVELOPMENTAL HISTORY

*Only complete this section if the patient is under 16 years old.*

What was the temperament of the child as a baby:

What developmental milestones did the child meet:

Six Months Old:
[ ] Sits Up without Support
[ ] Rolls Prone to Supine
[ ] Transfer Hand-to-Hand
[ ] Babbles
[ ] Stranger Anxiety

Nine Months Old:
[ ] Crawls
[ ] Says "Ma-Ma"
[ ] Says "Da-Da"

One Year Old:
[ ] Walks
[ ] Kicks and Throws Ball
[ ] Separation Anxiety

Two Years Old:
[ ] Runs
[ ] Aims While Throwing
[ ] Copies a Line
[ ] Two Word Sentences
[ ] Uses 250 Words

Three Years Old:
[ ] Toilet Trained
[ ] Copies a Circle
[ ] Can Ride a Tricycle
[ ] Knows Gender and Name
[ ] Complete Sentences
[ ] Catches Ball with Both Arms

Four Years Old:
[ ] Copies a Cross
[ ] Brushes Teeth
[ ] Hops on One Foot
[ ] Throws Overhand
[ ] Identifies Body Parts
[ ] Imitation of Adult Roles
[ ] Uses Complete Sentences

Five Years Old:
[ ] Copies Squares
[ ] Catches Ball with Hands
[ ] Complete Sphincter Control

*(Continued on next page)*

Patient Name: ________________________________
Date of Birth: ________________________________

| SCHOOL INFORMATION | | |
|---|---|---|
| *Only complete this section if the patient is under 16 years old.* | | |
| Name of School: | Academic Performance: | Current Grade Level: |
| Does the child have an IEP or 504: | [ ] Yes [ ] No | If yes, please specify: |
| Does the child have any behavioral difficulties at school (suspensions, expulsions, truancy): | [ ] Yes [ ] No | If yes, please list the behavioral difficulties: |
| Is the child bullied at school? [ ] Yes [ ] No | | |
| How are the child's relationships with their peers: | | |
| What hobbies, athletics interests, and skills does the child have? | | |

| FAMILY HISTORY | |
|---|---|
| Has anyone in your family ever been treated for a mental health or substance abuse problem? If so, please indicate below. | |
| Family Member: | Type of Problem: |
| Family Member: | Type of Problem: |
| Family Member: | Type of Problem: |
| Family Member: | Type of Problem: |
| Family Member: | Type of Problem: |
| Family Member: | Type of Problem: |

| SMOKING HISTORY | | | |
|---|---|---|---|
| Do you smoke tobacco? | [ ] No | [ ] Currently | [ ] Previously |

*(Continued on next page)*

Patient Name: ___________________________________
Date of Birth: ___________________________________

| CURRENT MEDICATIONS | | |
|---|---|---|
| Please list all medications, over the counter drugs, vitamins, and supplements that you are currently taking: | | |
| Medication/Vitamin/Supplement/etc.: | Strength: | How Often: |
| Medication/Vitamin/Supplement/etc.: | Strength: | How Often: |
| Medication/Vitamin/Supplement/etc.: | Strength: | How Often: |
| Medication/Vitamin/Supplement/etc.: | Strength: | How Often: |
| Medication/Vitamin/Supplement/etc.: | Strength: | How Often: |
| Medication/Vitamin/Supplement/etc.: | Strength: | How Often: |
| Medication/Vitamin/Supplement/etc.: | Strength: | How Often: |
| Medication/Vitamin/Supplement/etc.: | Strength: | How Often: |

*(Continued on next page)*

Adelpha
Psychiatric
Group

Patient Name: ________________________________

Date of Birth: ________________________________

## PSYCHIATRIC MEDICATION HISTORY

*Please indicate what medications you've tried below. Please describe anything you remember about its effect (helped, none, worse); problematic side effects; the highest dose you recall; and when and for how long you took it.*

| SSRIs | SNRIs | Heterocyclics | Tricyclics | MAOIs | Antianxiety |
|---|---|---|---|---|---|
| [ ] Celexa | [ ] Cymbalta | [ ] Brintellix | [ ] Anafranil | [ ] Emsam | [ ] Ativan |
| [ ] Lexapro | [ ] Effexor | [ ] Desyrel | [ ] Elavil | [ ] Nardil | [ ] BuSpar |
| [ ] Luvox | [ ] Fetzima | [ ] Remeron | [ ] Ludiomil | [ ] Parnate | [ ] Klonopin |
| [ ] Paxil | [ ] Pristiq | [ ] Serzone | [ ] Norpramin | | [ ] Librium |
| [ ] Pexeva | | [ ] Wellbutrin | [ ] Pamelor | | [ ] Neurontin |
| [ ] Prozac | | [ ] Viibryd | [ ] Sinequan | | [ ] Serax |
| [ ] Sarafem | | | [ ] Surmontil | | [ ] Tranxene |
| [ ] Zoloft | | | [ ] Tofranil | | [ ] Valium |
| | | | [ ] Vivactil | | [ ] Vistaril |
| | | | | | [ ] Xanax |

| Mood Stabilizers | Antipsychotics | | Sleep Meds | ADHD Meds | |
|---|---|---|---|---|---|
| [ ] Depakote | [ ] Abilify | [ ] Perphenazine | [ ] Ambien | [ ] Adderall | [ ] Ritalin |
| [ ] Lamictal | [ ] Clozaril | [ ] Prolixin | [ ] Benadryl | [ ] Clonadine | [ ] Strattera |
| [ ] Lithium | [ ] Fanapt | [ ] Risperdal | [ ] Dalmane | [ ] Concerta | [ ] Vyvanse |
| [ ] Tegretol | [ ] Geodon | [ ] Saphris | [ ] Halcion | [ ] Cylert | [ ] Wellbutrin |
| [ ] Topamax | [ ] Haldol | [ ] Seoquel | [ ] Lunesta | [ ] Daytrana | |
| [ ] Trileptal | [ ] Invega | [ ] Serentil | [ ] Placidyl | [ ] Dexedrine | |
| | [ ] Latuda | [ ] Stelazine | [ ] Prosom | [ ] Focalin | |
| | [ ] Loxitane | [ ] Thorazine | [ ] Restoril | [ ] Intuniv | |
| | [ ] Mellaril | [ ] Zyprexa | [ ] Rozerem | [ ] Metadate | |
| | [ ] Moban | | [ ] Somnote | [ ] Methylin | |
| | [ ] Navane | | [ ] Sonata | [ ] Nuvigil | |
| | [ ] Orap | | [ ] Vistaril | [ ] Provigil | |

Notes/Other medications not specified above:

*(end of questionnaire)*