PATIENT HEALTH HISTORY

PLEASE FILL OUT COMPLETELY

DATE:_____

NAME:_____ **AGE:**_____ **SEX:**_____ **HEIGHT:**_____ **WEIGHT:**_____

ADDRESS: _____ **CITY** _____ **STATE** _____ **HOME PHONE:** _____

WORK PHONE: _____ **OCCUPATION:** _____ **DATE OF BIRTH** _____

MARITAL STATUS _____ **ACCOMPANIED BY:** _____

REASON FOR VISIT _____

EMERGENCY CONTACT: _____ **EMERGENCY CONTACT PHONE:**_____

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

DISEASE	YES	NOW RESOLVED	NO	**DISEASE**	YES	NOW RESOLVED	NO	**DISEASE**	YES	NOW RESOLVED	NO
Asthma				Thyroid Disease				Mental Illness			
Stroke				Epilepsy/Convulsions				Mental Retardation			
Tumor				Glaucoma				Migraine			
Bleeding Disorder				Hair Loss				Osteoporosis			
Cancer				Heart Disease							
Depression				High Blood Pressure							
Diabetes				Kidney Disease							

If you answered **yes** to any of the above conditions, below please list when it was, what treatment you had and the outcome:

DATE	TREATMENT RECEIVED	OUTCOME

Date of last physical:_____ Primary Physician: _____

What medications are you currently taking (Specify name and dosage: This can be obtained from your pharmacy if you do not know.)

PRESCRIPTION *NON-PRESCRIPTION*

_____ _____

_____ _____

_____ _____

_____ _____

Are you allergic to or have you had adverse reactions to any medications? _____**YES** _____**NO**

If yes, specify type of reaction:_____

If above was a tranquilizing drug, describe your reaction:_____

Family History

Cancer	No	Yes	Who _____
Heart Disease	No	Yes	Who _____
High Blood Pressure	No	Yes	Who _____
Epilepsy	No	Yes	Who _____
Diabetes	No	Yes	Who _____
Depression	No	Yes	Who _____
Anxiety	No	Yes	Who _____
Bipolar Disorder	No	Yes	Who _____
Other psychiatric problems	No	Yes	Who _____
Suicides	No	Yes	Who _____
Substance abuse issues	No	Yes	Who _____
Other	No	Yes	Who _____

Do you smoke or use other tobacco?	No	Yes	How often _____
Do you drink alcohol?	No	Yes	How often _____
Do you use any other substances?	No	Yes	How often _____

Have you ever had any of the following forms of psychological treatments?

Individual therapy	No	Yes	Duration of therapy _____
Provided by _____			
Family therapy	No	Yes	Duration of therapy _____
Provided by _____			
Residential Treatment	No	Yes	Duration of Stay _____
Place of treatment _____			
Group Psychotherapy	No	Yes	Duration of treatment _____
Provided by _____			
Inpatient Eval/Treatment	No	Yes	Duration of Stay _____
Place of treatment _____			

Which of the following are considered to be a significant problem at the present time?

- ❑ Unrealistic worries about the future
- ❑ Unrealisitc concern about competence
- ❑ Marked self-consciousness
- ❑ Excessive need for reassureance
- ❑ Marked inability to relax
- ❑ Anxiety in social situations

When did these problems begin? _____

Which of the following are considered to be a significant problem at the present time?

- ❑ Fidgety
- ❑ Easily distracted
- ❑ Often losing things
- ❑ Talking excessively
- ❑ Difficulty sustaining attention

When did theses problems begin? _____

Which of the following are considered to be a significant problem at the present time?

- ❑ Often losing temper
- ❑ Often angry or resentful
- ❑ Easily annoyed by others

When did these problems begin? _____

Which of the following are considered to be a significant problem at the present time?

- ❑ Depressed/irritable mood most of the day nearly every day
- ❑ Diminished pleasure in activities
- ❑ Decrease/Increase (circle one if applicable) in appetite
- ❑ Insomnia
- ❑ Hypersomnia
- ❑ Fatigue or loss of energy
- ❑ Feelings of worthlessness or excessive guilt
- ❑ Diminished ability to concentrate
- ❑ Low self esteem
- ❑ Difficulty making decisions
- ❑ Feelings of hopelessness
- ❑ Suicidal ideation or attempt
- ❑ Never without symptoms for more than 2 months over a 1-year period

When did these problems begin? _____

Have you ever experienced the following?

- ❑ Overreaction to touch
- ❑ Compulsive rituals
- ❑ Motor tics (involuntary muscle movements)
- ❑ Vocal tics (involuntary noise making)
- ❑ Unusual fears
- ❑ Panic attacks
- ❑ Self-mutilations (cutting/burning on self, pulling hair out, etc.)
- ❑ Past suicidal ideation or attempt

Have you ever had any of the following diagnoses in the past?

- ❑ Major Depressive Disorder
- ❑ Generalized Anxiety Disorder
- ❑ Attention Deficit Disorder
- ❑ Bipolar Disorder
- ❑ Schizophrenia
- ❑ Learning Disabilities

PAIN ASSESSMENT

0	2	4	6	8	10
NO HURT	HURTS LITTLE BIT	HURTS LITTLE MORE	HURTS EVEN MORE	HURTS WHOLE LOT	HURTS WORST

CHRONIC PAIN: ❑ No ❑ Yes: Where?_____ Intensity: _____ (1=none > 10=extreme)
Present:_____ Relief measures:_____ Level of Relief:_____(1=none >10=good relief)
ACUTE PAIN: ❑ No ❑ Yes: Where?_____ Intensity: _____ (1=none > 10=extreme)
Present:_____ Relief measures:_____ Level of Relief: _____(1=none >10=good relief)

NUTRITION

Current Diet: _____ ❑ NOT A PROBLEM
Unintentional weight loss (>10 lbs. In past month) ❑ Yes ❑ No If yes, amount/length of time _____
❑ Difficulty chewing ❑ Swallowing ❑ Anorexia ❑ Bulimia ❑ Pregnancy ❑ Diabetes ❑ Ulcerations ❑ HIV/Aids
❑ Nausea/vomiting >5 days ❑ MAO inhibitors ❑ Heart disease
Questions about diet?_____
****ANY YES ANSWERS TO THE ABOVE - MUST INITIATE A CONSULT****

Teeth: ❑ intact ❑ caps ❑ loose ❑ none ❑ braces
Dentures: ❑ upper ❑ lower ❑ partial ❑ permanent
Mouth: ❑ moist ❑ dry ❑ bleeding gums
Last dental appointment:_____

FOLLOW-UP:

❑ Reviewed with Patient Comments: _____

❑ ***Requested that Pt. follow up with personal physician for any medical concerns/problems and have report sent to us.***

_____ _____
Provider Signature Date