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Initial Visit Health History Form
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Instructions: Please complete the enclosed form and email it back to me at least 3 days prior to your appointment. The information you provide will help me best address your concerns. Your responses will be kept as a confidential part of your medical record.

PATIENT INFORMATION:

Name (Last, First):	Email:	**Birthdate**:	**Age:**	
Home Address (street):		**Home Phone**:		
(City/State/Zip):		**Mobile Phone:**		

REFERRED BY: _____

Please indicate below why you are coming to see me, and why at this particular time. Please also describe briefly the history of your current situation.

SOCIAL HISTORY:

Birth place:		
Marital status: ☐Single ☐Married ☐Domestic Partnership ☐Divorced ☐ Widowed		
Highest level of education: ☐ Grade school ☐ High School ☐College ☐ Graduate School Names of college, grad school and degrees:		
Employment history: ☐ Currently employed		Occupation:
☐ Unemployed	Last worked (date):	Prior Occupation:
☐ Retired	☐ Disabled (date):	Disability Diagnosis:
Who lives at home with you?		

Please describe where you were raised, something about your family of origin, your educational and job experience, the nature and quality of your early and current relationships with family, and relationships with significant others and friends. Please help me understand what you consider your primary sources of support and stressors.

PSYCHIATRIC HISTORY:

Have you previously received psychiatric treatment? ☐ Yes ☐No
What prior diagnosis, if any, have you received? _____
Have you been hospitalized in the past for a psychiatric illness? ☐Yes ☐No
If yes, how many times? When? Where?
_____

Have you ever had (please circle)

Eating disorder	Yes	No	Details:_____
Manic episode	Yes	No	Details:_____
Panic disorder	Yes	No	Details:_____
OCD symptoms	Yes	No	Details:_____

Are there any details about your psychiatric history that would be helpful for me to know in preparation for our first visit?

SUBSTANCE, ALCOHOL, AND CIGARETTES:

Alcohol: do you drink? ☐ Yes ☐ No
If Yes, how much and how often? _____
Do you smoke cigarettes? ☐ Yes ☐ No If yes, how many per day? _____
Do you use drugs? ☐ Yes ☐ No
If yes, please describe the nature of the drugs you use, and frequency of use: _____
Is there a *past history* of substance use or abuse? ☐ Yes ☐ No

Past Psychiatric Medications:

Name	Dose	Length of time	Did it help?	Side Effects

☐ ECT (Electroconvulsive Therapy)
Dates of treatment: _____

☐ Psychotherapy
Dates of treatment: _____
Type(s) of psychotherapy: _____

GENERAL MEDICAL HISTORY:

Have you ever had any of the following conditions?

Condition	YES	NO	Condition	YES	NO
Heart attack			Liver disease/cirrhosis		
Heart failure			Gynecologic illness or condition		
Abnormal heart rhythm			HIV		
High blood pressure			Blood clots/DVT		
Diabetes/high blood sugar			Excessive bleeding		
Stroke			Bone loss/osteoporosis		
Asthma			Cancer		
Emphysema/COPD			Thyroid problem		
Stroke			Dementia		
Kidney Disease/Dialysis			Parkinson's Disease		
Kidney Stones			Glaucoma		

Please list any other medical problems that your doctors have diagnosed: _____

_____

Have you ever been pregnant? ☐ Yes ☐ No ☐ Unsure
If yes, how many times? _____
Do you plan on getting pregnant within the next year? ☐ Yes ☐ No ☐ Unsure
Are you using a form of birth control if sexually active? ☐ Yes ☐ No If so, what type: _____

At what age did you begin menstruating? _____ Are your periods regular? ☐ Yes ☐ No
How many days between menstrual periods? _____ Has this recently changed? ☐ Yes ☐ No
When was your last menstrual period? _____ Do you have hot flashes? ☐ Yes ☐ No

How many children have you delivered? _____ Are you breastfeeding? ☐ Yes ☐ No
Have you had a hysterectomy? ☐ Yes ☐ No
If you have had any other gynecological surgeries, please specify: _____

FAMILY HISTORY:

Please record the state of health of your close relatives:

RELATIVE	ALIVE? YES/NO	HEALTH PROBLEMS/CAUSE OF DEATH	AGE
Father			
Mother			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Sister/Brother			
Sister/Brother			
Sister/Brother			
Other:			
Other:			

Please indicate if ANY of your blood relatives has/had any of the following conditions

HEALTH PROBLEM	RELATIVE AFFECTED:
☐ Alcoholism	
☐ Drug Addiction	
☐ Schizophrenia	
☐ Bipolar Disorder	
☐ Depression	
☐ Anxiety	
☐ Dementia	
☐ Heart disease or stroke?	
☐ Parkinson's Disease	
☐ High Cholesterol	
☐ Diabetes	
☐ Hypertension	

Has anyone in your family attempted or completed suicide? _____Yes _____No
Has anyone in your family had a psychiatric hospitalization? _____Yes _____No

CURRENT MEDICATIONS:

Please list ALL medications you are currently taking or being prescribed, including over the counter medications.
☐ Currently, I am NOT taking ANY medications.

NAME	DOSE	How often?(i.e. twice a day)	How long have you been taking/prescribed this medication?	Has this medication been helpful?	Side Effects?

Please attach list of additional medications if list exceeds above space

Do you take any herbal supplements or vitamins? ☐Yes ☐No
If yes, please list below.

MEDICATION/FOOD ALLERGIES

☐ I have NO known food or drug allergies
Or...Please list ALL allergies and reactions to medications and food:

MEDICATION/FOOD	REACTION

REVIEW OF SYMPTOMS:
Please indicate any general medical symptoms you are experiencing (ex: headache, constipation, cough)

CONTACT INFORMATION FOR PROVIDERS/FAMILY MEMBERS

In order to provide you with the best possible care, please provide the contact information for your current treatment providers (i.e. primary care doctor, therapist, other clinicians), as well as for family members or friends that you want to be involved in your care.

Patient Name: _____

Date of Birth: _____

NB: Please sign the separate consent form to give Dr. Barchilon permission to speak with specific healthcare providers and/or family/friends.

Psychiatrist:

Name: _____

Address: _____

_____

Phone #_____

Family/Friends:

Name:_____

Phone #_____

Name:_____

Phone #_____

OB/Gynecologist:

Name:_____

Address:_____

_____

Phone #_____

Psychotherapist (if separate)

Name:_____

Address:_____

_____

Phone #_____

Other Healthcare Providers

Name:_____

Address:_____

_____

Phone #_____

Specialty: _____

THE MOOD DISORDER QUESTIONNAIRE

Instructions: Please answer each question to the best of your ability.

	YES	NO
1. Has there ever been a period of time when you were not your usual self and...		
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	○	○
...you were so irritable that you shouted at people or started fights or arguments?	○	○
...you felt much more self-confident than usual?	○	○
...you got much less sleep than usual and found you didn't really miss it?	○	○
...you were much more talkative or spoke much faster than usual?	○	○
...thoughts raced through your head or you couldn't slow your mind down?	○	○
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	○	○
...you had much more energy than usual?	○	○
...you were much more active or did many more things than usual?	○	○
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	○	○
...you were much more interested in sex than usual?	○	○
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	○	○
...spending money got you or your family into trouble?	○	○
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	○	○
3. How much of a problem did any of these cause you – like being unable to work; having family, money or legal troubles; getting into arguments or fights? *Please circle one response only.* No Problem Minor Problem Moderate Problem Serious Problem		
4. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	○	○
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	○	○

Adverse Childhood Experience (ACE) Questionnaire

Finding your ACE Score ra hbr 10 24 06

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often** …
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?
   Yes No If yes enter 1 _____

2. Did a parent or other adult in the household **often** …
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   Yes No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you **ever**…
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Try to or actually have oral, anal, or vaginal sex with you?
   Yes No If yes enter 1 _____

4. Did you **often** feel that …
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes No If yes enter 1 _____

5. Did you **often** feel that …
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No If yes enter 1 _____

6. Were your parents **ever** separated or divorced?
   Yes No If yes enter 1 _____

7. Was your mother or stepmother:
   Often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   Yes No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No If yes enter 1 _____

9. Was a household member depressed or mentally ill or did a household member attempt suicide?
   Yes No If yes enter 1 _____

10. Did a household member go to prison?
    Yes No If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these 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 _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.