Adult Initial Visit

Please complete all information to the best of your ability on this form and return it prior to your first visit. You may need to ask family members about the family history. This will allow for a productive initial visit for us. Information is confidential.

*Please bring or arrange to have past records or notes sent prior to your appointment.

Thank you and I look forward to meeting you!

Name____ Date_________________________

Date of Birth_________________________________ Primary Care Physician____

Who referred you to our clinic? ____

PRESENTING PROBLEM AND TREATMENT PLAN

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere? ◻ Yes ◻ No

Current Mental Health Provider____

Current Therapist/Counselor ____

Is mental health treatment court ordered? ◻ Yes ◻ No

What are the problem(s) for which you are seeking help?

1. ____
2. ____
3. ____

How long has this been going on? ____

What made you come at this time? ____

What are your treatment goals?

____

____

____

SUICIDE RISK ASSESSMENT

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

If YES, please answer the following. If NO, please skip to the next section.

Do you **currently** feel that you don't want to live? ◻ Yes ◻ No

How often do you have these thoughts? ____

When was the last time you had thoughts of dying? ____

Has anything happened recently to make you feel this way? ____

On a scale of 1 to 10, (ten being strongest) how strong is your desire to kill yourself currently?_______________________________

Would anything make it better?____

Have you ever thought about how you would kill yourself? ____

Is the method you would use readily available? ____

Have you planned a time for this? ____

Is there anything that would stop you from killing yourself? ____

Do you feel hopeless and/or worthless? ____

CURRENT SYMPTOMS CHECKLIST (please check all appropriate columns)

	Mild	Moderate	Severe		Mild	Moderate	Severe
Aggression	□	□	□	Increased libido	□	□	□
Agitation	□	□	□	Increased risky behavior	□	□	□
Anger	□	□	□	Irritability	□	□	□
Anxiety	□	□	□	Loneliness	□	□	□
Appetite Change	□	□	□	Loss of interest in activities	□	□	□
Concentration/forgetfulness	□	□	□	Memory impairment	□	□	□
Crying/tearful	□	□	□	Mood swings	□	□	□
Cyber addiction	□	□	□	Obsessions/repetitive thoughts	□	□	□
Decreased libido	□	□	□	Panic attacks	□	□	□
Decreased need for sleep	□	□	□	Paranoia/suspiciousness	□	□	□
Depressed mood	□	□	□	Poor concentration	□	□	□
Difficulty getting out of bed	□	□	□	Racing thoughts	□	□	□
Difficulty making decisions	□	□	□	Recurring thoughts	□	□	□
Distractibility	□	□	□	Sexual Addiction	□	□	□
Elevated mood	□	□	□	Sleep pattern disturbance	□	□	□
Excessive energy	□	□	□	Social isolation/avoidance	□	□	□
Fatigue	□	□	□	Substance abuse	□	□	□
Grief	□	□	□	Suicidal thoughts	□	□	□
Guilt	□	□	□	Suspiciousness	□	□	□
Gambling	□	□	□	Worried	□	□	□
Hallucinations	□	□	□	Worthlessness/low self-esteem	□	□	□
Hearing voices	□	□	□	Unable to enjoy things	□	□	□
Heart palpitations	□	□	□	Other:	□	□	□
Hopelessness	□	□	□	Other:	□	□	□
Hyperactivity	□	□	□				
Impulsivity	□	□	□				

SLEEP

Are you having any problems with your sleep habits? □ Yes □ No

If yes, check where applicable:

□ Sleeping too little □ Sleeping too much □ Poor quality sleep □ Nightmares

□ Other ____________________________

Do you take any medication to help with sleep? If, so what to you take/dose/how often?

____

Have you tried anything else to help with sleep? If so what? Did it help?

____

PERSONAL AND FAMILY MEDICAL HISTORY

	You	Family	Who?		You	Family	Who?
Alzheimer's/Dementia	□	□		Heart Disease	□	□	
Anemia	□	□		High Blood Pressure	□	□	
Arthritis	□	□		High Cholesterol	□	□	
Asthma/Respiratory Problems	□	□		HIV Positive or AIDS	□	□	
Behavioral Problems	□	□		Kidney Problems	□	□	
Birth Defects	□	□		Liver Disease	□	□	
Cancer	□	□		Liver Problems/Hepatitis	□	□	
Chronic Fatigue	□	□		Lung Disease	□	□	
Chronic Pain	□	□		Mental Retardation	□	□	
Diabetes	□	□		Migraine or Cluster Headaches	□	□	
Ear/Nose/Throat Problems	□	□		Neurological Problems	□	□	
Eating Disorder	□	□		Skin Disease	□	□	
Emotional Problems	□	□		Sleep Apnea	□	□	
Endocrine/Hormone Problems	□	□		Stroke	□	□	
Epilepsy or Seizures	□	□		Stomach or Intestinal Problems	□	□	
Eye Problems	□	□		Thyroid Disease	□	□	
Fibromyalgia	□	□		Tuberculosis	□	□	
Gastrointestinal Problems	□	□		Urological Problems	□	□	
Genital/Gynecological Problems	□	□		Viral Illness/Herpes	□	□	
Head Injury	□	□		Other:	□	□	

MEDICAL HISTORY

Current Medications (including over the counter)

Medication Name	Dosage	Estimated Start

List any known allergies:____

Current medical problems:

____

____

Prior illnesses or surgeries: ____

Have you ever had an EKG? □ Yes □ No If yes, when ______________________.

Was the EKG □ normal □ abnormal □ unknown

FOR WOMEN ONLY:

Date of last menstrual period _____________

Are you currently pregnant or do you think you might be pregnant? □ Yes □ No

Are you planning to get pregnant in the near future? □ Yes □ No

Birth control method ____________________ How many time have you been pregnant?______ How many live births?______

EMOTIONAL/PSYCHIATRIC HISTORY

Prior Outpatient Treatment—medication management with mental health provider? □ Yes □ No If yes, please describe:

Reason	Dates Treated	Where/By Whom

Prior Counseling/Therapy □ Yes □ No If yes, please describe:

Reason	Dates Treated	Where/By Whom

Prior Hospitalizations/Inpatient Treatment □ Yes □ No If yes, please describe:

Reason	Dates Treated	Where/By Whom

Have you ever attempted suicide? If so, how and when?

____

____

Do you have a history of or currently self harm? If yes, please describe:

____

TRAUMA HISTORY

Have you ever been abused?

□ Verbally □ Emotionally □ Physically □ Sexually □ Neglected

Please describe: ____

____

Please check if you have experienced any of the following types of trauma or loss.

□ Loss of a loved one □ Parent illness □ Parent substance abuse □ Witnessed death
□ Neglect □ Lived in a foster home □ Immigration trauma □ Military deployment
□ Homelessness □ Multiple family moves □ Human trafficking
□ Crime victim □ Violence in the home □ Gang violence
□ Other: ____

PAST PSYCHIATRIC MEDICATIONS

(If you have ever taken any of the following medications, indicate the date, dosage, and how helpful they were)

Antidepressants	**Check if taken**	**When?**	**Dosage?**	**Did it help?**	**Any side effects? What happened?**
Prozac (fluoxetine)	□			□ Yes □ No	□ Yes □ No
Zoloft (sertraline)	□			□ Yes □ No	□ Yes □ No
Luvox (fluvoxamine)	□			□ Yes □ No	□ Yes □ No
Paxil (paroxetine)	□			□ Yes □ No	□ Yes □ No
Celexa (citalopram)	□			□ Yes □ No	□ Yes □ No
Lexapro (escitalopram)	□			□ Yes □ No	□ Yes □ No
Effexor (venlafaxine)	□			□ Yes □ No	□ Yes □ No
Cymbalta (duloxetine)	□			□ Yes □ No	□ Yes □ No
Wellbutrin (bupropion)	□			□ Yes □ No	□ Yes □ No
Remeron (mirtazapine)	□			□ Yes □ No	□ Yes □ No
Serzone (nefazodone)	□			□ Yes □ No	□ Yes □ No
Anafranil (clomipramine)	□			□ Yes □ No	□ Yes □ No
Pamelor (nortriptyline)	□			□ Yes □ No	□ Yes □ No
Tofranil (imipramine)	□			□ Yes □ No	□ Yes □ No
Elavil (amitriptyline)	□			□ Yes □ No	□ Yes □ No
Trintellix (vortioxetine)	□			□ Yes □ No	□ Yes □ No
Pristiq (desvenlafaxine)	□			□ Yes □ No	□ Yes □ No
Desyrel (trazadone)	□			□ Yes □ No	□ Yes □ No
Viibryd (vilazodone)	□			□ Yes □ No	□ Yes □ No
Ludiomil (maprotiline)	□			□ Yes □ No	□ Yes □ No
Norpramin (desipramine)	□			□ Yes □ No	□ Yes □ No
Antipsychotics	**Check if taken**	**When?**	**Dosage?**	**Did it help?**	**Any side effects? What happened?**
Seroquel (quetiapine)	□			□ Yes □ No	□ Yes □ No
Zyprexa (olanzapine)	□			□ Yes □ No	□ Yes □ No
Geodon (ziprasidone)	□			□ Yes □ No	□ Yes □ No
Abilify (aripiprazole)	□			□ Yes □ No	□ Yes □ No
Clozaril (clozapine)	□			□ Yes □ No	□ Yes □ No
Haldol (haloperidol)	□			□ Yes □ No	□ Yes □ No
Prolixin (fluphenazine)	□			□ Yes □ No	□ Yes □ No
Risperdal (risperidone)	□			□ Yes □ No	□ Yes □ No
Mood Stabilizers	**Check if taken**	**When?**	**Dosage?**	**Did it help?**	**Any side effects? What happened?**
Depakote (valproate)	□			□ Yes □ No	□ Yes □ No
Lithium	□			□ Yes □ No	□ Yes □ No
Lamictal (lamotrigine)	□			□ Yes □ No	□ Yes □ No
Topamax (topiramate)	□			□ Yes □ No	□ Yes □ No
Tegretol (carbamazepine)	□			□ Yes □ No	□ Yes □ No
Sedative/Hypnotics	**Check if taken**	**When?**	**Dosage?**	**Did it help?**	**Any side effects? What happened?**
Ambien (zolpidem)	□			□ Yes □ No	□ Yes □ No
Lunesta (Eszopiclone)	□			□ Yes □ No	□ Yes □ No
Sonata (zaleplon)	□			□ Yes □ No	□ Yes □ No
Restoril (temazepam)	□			□ Yes □ No	□ Yes □ No
Desyrel (trazodone)	□			□ Yes □ No	□ Yes □ No
ADHD Medications	**Check if taken**	**When?**	**Dosage?**	**Did it help?**	**Any side effects? What happened?**
Adderall (amphetamine)	□			□ Yes □ No	□ Yes □ No
Concerta (methylphenidate)	□			□ Yes □ No	□ Yes □ No
Ritalin (methylphenidate)	□			□ Yes □ No	□ Yes □ No
Strattera (atomoxetine)	□			□ Yes □ No	□ Yes □ No
Antianxiety Medications	**Check if taken**	**When?**	**Dosage?**	**Did it help?**	**Any side effects? What happened?**
Xanax (alprazolam)	□			□ Yes □ No	□ Yes □ No
Ativan (lorazepam)	□			□ Yes □ No	□ Yes □ No
Klonopin (clonazepam)	□			□ Yes □ No	□ Yes □ No
Valium (diazepam)	□			□ Yes □ No	□ Yes □ No
Buspar (buspirone)	□			□ Yes □ No	□ Yes □ No
Other Medications (specify)	**Check if taken**	**When?**	**Dosage?**	**Did it help?**	**Any side effects? What happened?**
	□			□ Yes □ No	□ Yes □ No
	□			□ Yes □ No	□ Yes □ No

FAMILY PSYCHIATRIC HISTORY

	Father	Mother	Aunt	Uncle	Brother	Sister	Children	Grandparent
Depression	□	□	□ Maternal □ Paternal	□ Maternal □ Paternal	□	□	□	□ Maternal □ Paternal
Anxiety	□	□	□ Maternal □ Paternal	□ Maternal □ Paternal	□	□	□	□ Maternal □ Paternal
Anger	□	□	□ Maternal □ Paternal	□ Maternal □ Paternal	□	□	□	□ Maternal □ Paternal
Panic Attacks	□	□	□ Maternal □ Paternal	□ Maternal □ Paternal	□	□	□	□ Maternal □ Paternal
Bipolar Disorder/Manic Depression	□	□	□ Maternal □ Paternal	□ Maternal □ Paternal	□	□	□	□ Maternal □ Paternal
Schizophrenia	□	□	□ Maternal □ Paternal	□ Maternal □ Paternal	□	□	□	□ Maternal □ Paternal
Alcohol Problems	□	□	□ Maternal □ Paternal	□ Maternal □ Paternal	□	□	□	□ Maternal □ Paternal
Drug Problems	□	□	□ Maternal □ Paternal	□ Maternal □ Paternal	□	□	□	□ Maternal □ Paternal
ADHD	□	□	□ Maternal □ Paternal	□ Maternal □ Paternal	□	□	□	□ Maternal □ Paternal
Suicide Attempts	□	□	□ Maternal □ Paternal	□ Maternal □ Paternal	□	□	□	□ Maternal □ Paternal
Psychiatric Hospitalization	□	□	□ Maternal □ Paternal	□ Maternal □ Paternal	□	□	□	□ Maternal □ Paternal
Violence	□	□	□ Maternal □ Paternal	□ Maternal □ Paternal	□	□	□	□ Maternal □ Paternal

Has any family member been treated with a psychiatric medication? □ Yes □ No

If yes, who was treated, what medications did they take, and how effective was the treatment?
____
____

SUBSTANCE USE (INFORMATION IS CONFIDENTIAL)

Do you think you may have a problem with alcohol or drug use? □ Yes □ No
Have you ever been treated for alcohol or drug use abuse? □ Yes □ No
If yes, for which substance(s)?

If yes, where were you treated and when?

ALCOHOL HISTORY

How many days per week do you drink any alcohol? _______________
What is the least number of drinks you will drink in a day? _______________
What is the most number of drinks you will drink in a day? _______________
In the past three months, what is the largest number of alcoholic drinks you have consumed in one day? _______________
Have you ever felt you should cut down on your drinking or drug use? □ Yes □ No
Have people annoyed you by criticizing your drinking or drug use? □ Yes □ No
Have you ever felt bad or guilty about your drinking or drug use? □ Yes □ No
Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? □ Yes □ No

SUBSTANCE HISTORY:

Check if you have ever tried the following:

	Yes	No	If yes, how long and when did you last use?
Methamphetamine	□	□	
Cocaine	□	□	
Stimulants (pills)	□	□	
Heroin	□	□	
LSD or Hallucinogens	□	□	
Marijuana	□	□	
Pain Medication (not as prescribed)	□	□	
Methadone	□	□	
Sedatives/Sleeping Pills	□	□	
Ecstasy	□	□	
Other:	□	□	

Have you ever abused prescription medication? □ Yes □ No If yes, which one(s) and for how long?
____

How many caffeinated beverages do you drink a day? Coffee _________ Sodas ________ Tea ________ Energy Drinks ________

TOBACCO HISTORY

Have you ever smoked cigarettes? □ Yes □ No
Currently? □ Yes □ No How many packs per day on average? ________ How many years? _________
Past? □ Yes □ No How many years did you smoke? _________ When did you quit? _________

Cigars or chewing tobacco:
Currently? □ Yes □ No Past? □ Yes □ No
What kind? ___________________ How often per day on average? ________ How many years? ________

LEGAL HISTORY

	CURRENT	PAST	REASON
Served Jail Time	□	□	________________________
Probation	□	□	________________________
Parole	□	□	________________________
Power of Attorney	□	□	________________________
Court Committal to Treatment	□	□	________________________
DHS Involvement	□	□	________________________

Are you currently involved in any divorce or child custody proceedings? If yes, please explain ________________________________
____

FAMILY BACKGROUND AND CHILDHOOD HISTORY

Were you adopted? □ Yes □ No Where were you born?____
Where did you grow up? ____
List your siblings and their ages: ____
____
What is your relationship with your siblings?: ____
____
____
What was your father's occupation? ____
What was your mother's occupation? ____
Did your parents divorce? □ Yes □ No If so, how old were you when they divorced? ______________________
If your parents divorced, who did you live with? ____
Describe your father and your relationship with him: ____
____
____
Describe your mother and your relationship with her: ____
____
____
How old were you when you left home? ____
Has anyone in your immediate family died? If so, who and when? ___________________________________

RELATIONSHIP HISTORY AND CURRENT FAMILY

Are you currently: □ Married □ Partnered □ Divorced □ Single □ Widowed
How long? _______________
If not married, are you currently in a relationship? □ Yes □ No If yes, how long? _________________________
How would you identify your sexual orientation?
□ straight/heterosexual □ lesbian/gay/homosexual □ bisexual □ transsexual
□ unsure/questioning □ asexual □ other □ prefer not to answer
What is your spouse or significant other's occupation? ____
Describe your relationship with your spouse or significant other: ___________________________________
Have you had any prior marriages? □ Yes □ No If so, how many? ______________ How long? ______________
Do you have any children? □ Yes □ No If yes, names and ages: ____________________________________
____
____
Describe your relationship with your children: ____
____
____

Who currently lives in your residence?

Name	Relationship to You	Age	Quality of Relationship

SOCIO-ECONOMIC HISTORY

Living Situation:	**Employment:**	**Social Support System:**	**Financial Situation:**
☐ Housing adequate ☐ Homeless ☐ Housing overcrowded ☐ Dependent on others for housing ☐ Housing dangerous/ deteriorating ☐ Living companions dysfunctional	☐ Employed and satisfied ☐ Employed and dissatisfied ☐ Unemployed ☐ Coworker conflicts ☐ Supervisor conflicts ☐ Unstable work history ☐ Disabled:	☐ Supportive network ☐ Few friends ☐ Substance-use-based friends ☐ No friends ☐ Distance from family of origin	☐ No current financial problems ☐ Large indebtedness ☐ Poverty or below-poverty income ☐ Impulsive spending ☐ Relationship conflicts over finances

OCCUPATIONAL HISTORY

Are you currently:
☐ Working ☐ Unemployed/reason:________________________________ ☐ Disabled/reason:_______________________________
☐ Retired ☐ Student
What is/was your occupation? _______________________________ How long in present position?___________________________
Are you happy with your current position? ____
Please list work related stressors, if any:_ ____
____
Have you ever served in the military? _________ If so, what branch and when? ____
Honorable discharge? ☐ Yes ☐ No Other type of discharge: ____

What kind of social activities do you participate in/enjoy?
____
____

SPIRITUAL LIFE

Do you belong to a particular religion or spiritual group? ☐ Yes ☐ No
If yes, what is your religion and level of involvement?____
If no, do you consider yourself to be spiritual?____
Do you find religion/spirituality to be helpful for you?____

ADDITIONAL INFORMATION

In the last year, have you experienced any significant life changes or stressors?

Is there anything else that you would like me to know?

Signature ____ Date ____

Emergency Contact ____ Telephone # ____________________________________