



**Stonebriar Psychiatric Services, PA**  
**Medical and Social History**

Have you recently had:  Weakness  Fever  Chills  
 Fainting  Problems Sleeping  Night Sweats

CIRCLE if you have had the following:

SKIN

Skin Disease ..... Yes No  
Jaundice ..... Yes No  
Hives, eczema, rash ..... Yes No

Head-Eyes-Ears-Nose-Throat

Dry eyes or mouth ..... Yes No  
Bleeding gums – frequent or consistent ..... Yes No  
Blurred vision ..... Yes No  
Date of last eye exam \_\_\_\_\_  
Nosebleeds – frequent ..... Yes No  
Chronic sinus trouble ..... Yes No  
Ear disease ..... Yes No  
Impaired hearing ..... Yes No  
Dizziness or sensation of room spinning ..... Yes No  
Frequent or severe headaches ..... Yes No

Respiratory

Asthma or Wheezing ..... Yes No  
Difficulty breathing ..... Yes No  
Pleurisy or Pneumonia ..... Yes No  
Cough up Blood (ever) ..... Yes No

Cardiovascular

Chest pain, pressure or tightness ..... Yes No  
Shortness of breath with walking or lying down ..... Yes No  
Palpitations ..... Yes No  
Swelling of hands, feet or ankles ..... Yes No  
Awakening in the nights feeling smothered ..... Yes No  
Heart murmur ..... Yes No

Gastrointestinal

Vomiting blood or food ..... Yes No  
Gallbladder disease ..... Yes No  
Change in appetite ..... Yes No  
Hepatitis / Jaundice ..... Yes No  
Painful bowel movements ..... Yes No  
Bleeding with bowel movements ..... Yes No  
Black stools ..... Yes No  
Recent change in bowel habits ..... Yes No  
Frequent diarrhea ..... Yes No  
Heartburn or indigestion ..... Yes No  
Cramping or pain in the abdomen ..... Yes No  
Does food stick in throat ..... Yes No

Endocrine

Hormone therapy ..... Yes No  
Any change in hat or glove size ..... Yes No  
Any change in hair growth ..... Yes No  
Have you become colder than before or skin dryer ..... Yes No

Neck

Stiffness ..... Yes No  
Enlarged glands ..... Yes No

Genitourinary:

Loss of urine ..... Yes No  
Blood in urine ..... Yes No  
Frequent urination ..... Yes No  
Burning or painful urination ..... Yes No  
Bedwetting ..... Yes No  
Kidney trouble ..... Yes No  
Testicular mass ..... Yes No  
Prostate problem ..... Yes No  
Sexual dysfunction ..... Yes No  
STD / AIDS risk ..... Yes No

Gynecological:

First day of last period \_\_\_\_\_  
Age periods started \_\_\_\_\_  
How long do periods last \_\_\_\_\_  
Frequency of periods every \_\_\_\_\_  
Pain with periods ..... Yes No  
Number of pregnancies \_\_\_\_\_  
Number of miscarriages \_\_\_\_\_  
Date of last cancer smear and results \_\_\_\_\_  
Breast lump or discharge ..... Yes No  
Abnormal vaginal discharge ..... Yes No  
Pain with intercourse ..... Yes No

Locomotor-musculoskeletal

Stiffness or pain in joints ..... Yes No  
Weakness of muscles or joints ..... Yes No  
Any difficulty walking ..... Yes No  
Any pain in calves/buttocks with walking relieved w/rest ... Yes No

Neuro-Psychiatric

Transient blindness  Tremor  Weakness  Fingers numb  
Have you ever had counseling for mental health ..... Yes No  
Have you ever been advised to see a psychiatrist ..... Yes No  
Have you or do you ever have fainting spells ..... Yes No  
Convulsions ..... Yes No  
Paralysis ..... Yes No  
Problems with coordination ..... Yes No  
History of being physically or sexually abused ..... Yes No  
Depression symptoms (difficulty sleeping, loss of appetite,  
loss of interest in activities, feeling hopeless ..... Yes No  
History of ADHD ..... Yes No  
History of mood swings or bipolar illness ..... Yes No  
History of bingeing or purging ..... Yes No

Hematologic

Are you slow to heal after cuts ..... Yes No  
Anemia ..... Yes No  
Phlebitis or blood clots in veins ..... Yes No  
Have you had difficulty with bleeding excessively  
after tooth extraction or surgery? ..... Yes No  
Have you had abnormal bruising or bleeding ..... Yes No

**The information provided herein is accurate to the best of my knowledge. I understand it is my responsibility to inform my doctor of any changes in this information.**

Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_ Provider: \_\_\_\_\_

Signature of person providing this information: \_\_\_\_\_

Source of information, if other than patient: \_\_\_\_\_

*Stonebriar Psychiatric Services, PA*  
*Medical and Social History*  
**Stonebriar Psychiatric Services, P.A.**

***Patient Intake Form***

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Home Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

*May we leave messages at home?*    Yes    No

*May we leave messages at work?*    Yes    No

*May we send mail to you at this address?*    Yes    No

Marital Status:    S    M    D    W                      Date of Current Marriage/Separation: \_\_\_\_\_

Number of Marriages: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Child(ren)'s Name(s): \_\_\_\_\_ Date of Birth: \_\_\_\_\_  M    F

\_\_\_\_\_ Date of Birth: \_\_\_\_\_  M    F

\_\_\_\_\_ Date of Birth: \_\_\_\_\_  M    F

Previously Married?    Yes    No                      If yes, when? \_\_\_\_\_                      How long? \_\_\_\_\_

Occupation: \_\_\_\_\_ Highest Level of Education: \_\_\_\_\_

**COUNSELING AND PSYCHIATRIC HISTORY**

Have you had previous counseling?    Yes    No   If yes, when? \_\_\_\_\_

Name and location of counselor: \_\_\_\_\_

If yes, for what reason? \_\_\_\_\_

For how long? \_\_\_\_\_ Was it helpful? \_\_\_\_\_

Have you ever been diagnosed with or treated for any type of mental illness?    Yes    No   If yes, which type? \_\_\_\_\_

\_\_\_\_\_

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Has anyone in your family ever been diagnosed with or treated for any type of mental illness?  Yes  No

If yes, who and which type? \_\_\_\_\_

**REASONS FOR SEEKING HELP**

What concerns have brought you to counseling today? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Which of the following are causing the most concern for you? Please check all that apply:

- Home  Work  Marriage  Other Relationships  God

When did your present concerns begin to be a problem for you? \_\_\_\_\_

What concerns about you have been identified by others? \_\_\_\_\_

\_\_\_\_\_

**Please rate the severity of your present concerns on the following scale.** Check one:

- Mild  Moderate  Severe  Totally Incapacitating

Please indicate which of the following areas are currently problematic for you. Check all that apply:

- |   |  |
|---|--|
| <input type="checkbox"/> Blackouts or temporary loss of memory        | <input type="checkbox"/> Inability to concentrate while at school/work                             |
| <input type="checkbox"/> Insomnia (not being able to sleep)           | <input type="checkbox"/> Crying spells   |
| <input type="checkbox"/> Loss of appetite/increased appetite          | <input type="checkbox"/> Feeling "on top of the world"   |
| <input type="checkbox"/> Uncontrollable anxiety or worry              | <input type="checkbox"/> Nightmares  |
| <input type="checkbox"/> Lacking self-confidence                      | <input type="checkbox"/> Loss of interest in usual activities/lack of motivation                   |
| <input type="checkbox"/> Feeling fat                                  | <input type="checkbox"/> Obsessions or compulsions with specific activities                        |
| <input type="checkbox"/> Eating and then vomiting to control weight   | <input type="checkbox"/> Inability to control thoughts   |
| <input type="checkbox"/> Excessive use of alcohol                     | <input type="checkbox"/> Feeling trapped in rooms/buildings  |
| <input type="checkbox"/> Abuse of non-prescription drugs              | <input type="checkbox"/> Hearing voices  |
| <input type="checkbox"/> Getting into trouble at school/work          | <input type="checkbox"/> Feeling that people are "out to get you" or that you are<br>being watched |
| <input type="checkbox"/> Feeling inferior to others                   | <input type="checkbox"/> Angry outbursts   |
| <input type="checkbox"/> Under too much pressure and feeling stressed | <input type="checkbox"/> Excessive fear of specific places or objects                              |
| <input type="checkbox"/> Feeling down or unhappy/depressed mood       | <input type="checkbox"/> Difficulty making friends   |
| <input type="checkbox"/> Excessive anxiety or worry                   | <input type="checkbox"/> Difficulty maintaining friendships  |
| <input type="checkbox"/> Feeling lonely                               | <input type="checkbox"/> Feeling as if you'd be better off dead                                    |
| <input type="checkbox"/> Suspicious feelings toward other people      | <input type="checkbox"/> Feeling manipulated or controlled by others                               |
| <input type="checkbox"/> Afraid of being on your own                  | <input type="checkbox"/> Difficulty making decisions   |
| <input type="checkbox"/> Angry feelings                               |  |

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- |  |  |
|--|--|
| <input type="checkbox"/> Concerns about finances                 | <input type="checkbox"/> Loss of interest in sexual relationships              |
| <input type="checkbox"/> Feeling “numb” or cut off from emotions | <input type="checkbox"/> Feeling sexually attracted to members of your own sex |
| <input type="checkbox"/> Concerns about physical health          | <input type="checkbox"/> Feeling distant from God                              |
| <input type="checkbox"/> Concerns about emotional stability      | <input type="checkbox"/> Hallucinations  |
| <input type="checkbox"/> Tremors                                 | <input type="checkbox"/> Hypersomnia (sleeping all the time)                   |
| <input type="checkbox"/> Delusions                               | <input type="checkbox"/> Not being able to say what you really think or feel   |

Other: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What would you like to gain from counseling? \_\_\_\_\_  
\_\_\_\_\_

How did you hear about us? \_\_\_\_\_

**SPIRITUALITY**

Do you believe in God?  Yes  No What is your religious preference? \_\_\_\_\_

Are you a member of a church?  Yes  No If yes, what church? \_\_\_\_\_

How much influence does your religion have on your day-to-day activity?  A lot  A moderate amount  A little  None

**EMERGENCY CONTACT**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

**(Next of Kin – Other than Spouse)**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_