

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 DiseaseYes No
 JaundiceYes No
 Hives, eczema, rash.....Yes No

Head-Eyes-Ears-Nose-Throat

Dry eyes or mouthYes No
 Bleeding gums – frequent or consistentYes No
 Blurred vision.....Yes No
 Date of last eye exam _____
 Nosebleeds – frequentYes No
 Chronic sinus troubleYes No
 Ear diseaseYes No
 Impaired hearingYes No
 Dizziness or sensation of room spinningYes No
 Frequent or severe headachesYes No

Respiratory

Asthma or WheezingYes No
 Difficulty breathingYes No
 Pleurisy or PneumoniaYes No
 Cough up Blood (ever)Yes No

Cardiovascular

Chest pain, pressure or tightnessYes No
 Shortness of breath with walking or lying downYes No
 PalpitationsYes No
 Swelling of hands, feet or anklesYes No
 Awakening in the nights feeling smotheredYes No
 Heart murmurYes No

Gastrointestinal

Vomiting blood or foodYes No
 Gallbladder diseaseYes No
 Change in appetiteYes No
 Hepatitis / JaundiceYes No
 Painful bowel movementsYes No
 Bleeding with bowel movementsYes No
 Black stoolsYes No
 Recent change in bowel habitsYes No
 Frequent diarrheaYes No
 Heartburn or indigestionYes No
 Cramping or pain in the abdomenYes No
 Does food stick in throatYes No

Endocrine

Hormone therapyYes No
 Any change in hat or glove sizeYes No
 Any change in hair growthYes No
 Have you become colder than before or skin dryerYes No

Neck

StiffnessYes No
 Enlarged glandsYes No

Genitourinary:

Loss of urineYes No
 Blood in urineYes No
 Frequent urinationYes No
 Burning or painful urinationYes No
 BedwettingYes No
 Kidney troubleYes No
 Testicular massYes No
 Prostate problemYes No
 Sexual dysfunctionYes No
 STD / AIDS riskYes No

Gynecological:

First day of last period _____
 Age periods started _____
 How long do periods last _____
 Frequency of periods every _____
 Pain with periodsYes No
 Number of pregnancies _____
 Number of miscarriages _____
 Date of last cancer smear and results _____
 Breast lump or dischargeYes No
 Abnormal vaginal dischargeYes No
 Pain with intercourseYes No

Locomotor-musculoskeletal

Stiffness or pain in jointsYes No
 Weakness of muscles or jointsYes No
 Any difficulty walkingYes 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 healthYes No
 Have you ever been advised to see a psychiatristYes No
 Have you or do you ever have fainting spellsYes No
 Convulsions.....Yes No
 ParalysisYes No
 Problems with coordinationYes No
 History of being physically or sexually abusedYes No
 Depression symptoms (difficulty sleeping, loss of appetite,
 loss of interest in activities, feeling hopelessYes No
 History of ADHDYes No
 History of mood swings or bipolar illnessYes No
 History of bingeing or purgingYes No

Hematologic

Are you slow to heal after cutsYes No
 AnemiaYes No
 Phlebitis or blood clots in veinsYes No
 Have you had difficulty with bleeding excessively
 after tooth extraction or surgery?Yes No
 Have you had abnormal bruising or bleedingYes No

Other

Do you snore loud enough to be heard through a closed door? Yes No
 Do you often feel tired, fatigued during the day?Yes No
 Has anyone observed you stop breathing during sleep?..... Yes No
 Do you have/are you being treated for high blood pressure? 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: _____

*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? _____

Stonebriar Psychiatric Services, PA
Medical and Social History

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
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 | |

Stonebriar Psychiatric Services, PA
Medical and Social History

- | | |
|--|--|
| <input type="checkbox"/> Afraid of being on your own | <input type="checkbox"/> Feeling manipulated or controlled by others |
| <input type="checkbox"/> Angry feelings | <input type="checkbox"/> Difficulty making decisions |
| <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: _____