MD Psychiatry & Emotional Health, PLLC

Help. Heal. Hope.

Your Emotional Health

The purpose of this form is to obtain preliminary information about you, your background, and some of the more important events in your life. All information will be filed in your clinical chart and is kept **strictly confidential**. Disclosure of any part or all of your chart requires your written consent. Please fill in as much information as possible. Please print or write legibly. *Please leave blank if not applicable.*

Name _____ **Age** _____ **DOB** _____ **Date** _____

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

_____

What are your treatment goals?

_____

Referred by: MD _____ Therapist _____ Friend _____ Internet _____

Significant Life Events

Please check all that apply and provide age of event:

( ) Physical Abuse ___ (age) ( ) Emotional Abuse ___ ( ) Sexual Abuse ___

( ) Loss of Parent ___ ( ) Loss of spouse/sibling ___ ( ) Loss of Job___

( ) Financial Stress ___ ( ) Motor Vehicle Accident ___ ( ) Stress at Work ___

( ) Conflict with Spouse ___ ( ) Conflict with Parent/Sibling ___ ( ) **Other** (Explain)

Other: _____

Self-Description of your Current Symptoms/Challenges

Current Symptoms Checklist: (check once for any symptoms present, twice for major symptoms)

( ) Depressed mood ( ) Racing thoughts ( ) Excessive worry

( ) Unable to enjoy activities ( ) Impulsivity ( ) Anxiety attacks

( ) Sleep pattern disturbance ( ) Increase risky behavior ( ) Avoidance

( ) Loss of interest ( ) Increased libido ( ) Hallucinations

( ) Concentration/forgetfulness ( ) Decreased need for sleep ( ) Suspiciousness

( ) Change in appetite ( ) Excessive energy ( ) Excessive energy

( ) Excessive guilt ( ) Increased Irritability ( ) Fatigue

( ) Crying Spells ( ) Decrease libido ( ) Other _____

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Past Psychiatric History

Outpatient treatment ( ) Yes ( ) No If yes, Please describe when, by whom, and nature of treatment.

Reason	**Dates Treated**	**By Whom**

Psychiatric Hospitalization ( ) Yes ( ) No If yes, describe for what reason, when and where.

Reason	**Date**	**Hospitalized Where**

What Psychiatric medications are you CURRENTLY taking and why?

Name of Medication	Dosage	Why do you take it

Your Suicidal History/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 the strongest) how strong is your desire to kill yourself? _____

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

Have you ever developed a plan to kill yourself? _____

Have you ever tried to harm or kill yourself before? _____

If yes, please explain month/year and what happened?

_____

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Relationship and Marital History

Please give us some information about your significant partners/spouses

Spouse/Partners Name	Your Age	Years Together	Current Relationship
1. _____	_____	_____	__ Positive __ Negative __Challenging
2. _____	_____	_____	__ Positive __ Negative __Challenging
3. _____	_____	_____	__ Positive __ Negative __Challenging
4. _____	_____	_____	__ Positive __ Negative __Challenging

What else would you like us to know about? _____

_____

_____

_____

Signature: _____ Date _____

Guardian Signature (if under age 18) _____ Date _____

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