COMPREHENSIVE PSYCHIATRIC ASSOCIATES, LLC

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NEW PATIENT HISTORY - Adult

NAME OF PATIENT _____ AGE _____ SEX _____

DATE & PLACE OF BIRTH _____ Today's Date _____

ADDRESS _____

CITY _____ STATE _____

ZIP CODE _____ PHONE _____ (Home)

_____ (Work)

Please let us know how you were referred to our clinic: PRIVATE PHYSICIAN: _____

Name of referral source: _____

PRESENTING PROBLEMS:

In the space provided below, list your problems or other needs we may assist you with. Please include details:

_____

_____

_____

_____

_____

_____

Please circle if your problems fall into the categories listed below:

Alcohol/Drug Problems Change in Energy Level Change in Sleep Pattern Concentrating / Remembering Depression
Difficulty Relating to Others Divorce Drug Problems Family Problems Feel People Are Against You
Financial Trouble Hallucinations Headaches Hearing Voices Indecisiveness Job Difficulties Loneliness
Marital Problems Nervousness / Tension Physical Problems** Poor Self-Control Poor Self-Image
Sexual Difficulties Shyness Stomach Problems Temper

(**For Physical Problems, Please Refer To Page 2)

How long have these problems existed? In days, weeks, months, or years?

Have you had similar problems in the past? If yes, Please explain:

Do you feel you have additional problems?

Do you know what brought your problem(s) on?

What did you do that helped your problems now or in the past?

Please circle which of the following you enjoy?

Education Family Friends Good Health Good Income Hobbies/Recreation Life Experience
Medication Mental Strength / Willpower Occupation Religion / Spiritual Beliefs Support Group

Do you have any relatives with similar problems? (i.e. mental illness, emotional problem, alcoholism, depression, learning disabilities, etc.)

PHYSICAL PROBLEMS (please circle all symptoms you are currently experiencing):

Weakness / Fatigue Fever / Chills Change in Weight Change in Appetite Bleeding / Bruising
Double Vision Visual Abnormalities Glaucoma Hearing Loss Ringing In The Ears
Bleeding Nose Hay fever Sinus Problems Dental Problems
Chest Pain Heart Problems Lung Problems Shortness of Breath Persistent Cough
Coughing Up Blood Asthma Respiratory Problems Hypertension Varicose Veins Leg Swelling
Difficulty Swallowing Abdominal Pain Ulcer Nausea Vomiting Blood in Vomit
Jaundice Hepatitis Diarrhea Constipation Change in Bowels
Painful Urination Blood in Urine Urination Problems Kidney Stones Venereal Disease
Impotence / Less Sexual Interest Testicle Pain / Swelling Painful Menstruation Vaginal Discharge
Problems with Pregnancy
Arthritis Joint Pain Back Pain
Diabetes Swollen Thyroid Glands Acne Psoriasis Skin Conditions
Headaches Seizures Dizziness Fainting Shakiness Abnormal Motor Functions

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DRUG and ALCOHOL HISTORY:

List below all forms of alcohol, illegal and prescription drugs which you have used. Do not include prescription medication which you did not use. _____

_____

How much of each of the following substances do you use in an average day?

Alcohol: _____Nicotine:_____

Caffeine (coffee, tea, coke, etc.):_____Other:_____

At what age did you begin using drugs and/or alcohol?_____

Have you ever received treatment for drug and/or alcohol problems? If yes, please give details. _____

_____

MEDICAL and PSYCHIATRIC HISTORY:

Please list all surgical, medical, or psychiatric treatment given you on either an outpatient or inpatient basis.

_____

_____

_____

_____

_____

_____

_____

Are you currently being treated for a physical illness? If yes, please explain: _____

_____

List all medications (prescription and over the counter) you are currently taking: _____

_____

List all medications (prescription and over the counter) you have taken in the past: _____

_____

Are you allergic to any medication or have other allergies? _____

_____

FAMILY HISTORY:

Mother's Name: _____ Age: _____
Circle your relationship to your mother: Natural Adoptive Step Foster
If deceased, cause of death _____ When? _____

Occupation of mother: _____ Level of education: _____

Father's Name: _____ Age: _____
Circle your relationship to your father: Natural Adoptive Step Foster
If deceased, cause of death _____ When? _____

Occupation of father: _____ Level of education: _____

Circle your parent's present marital status: Married Single Divorced Separated Widowed

If divorced, at what age did the divorce occur? _____ Who was the custodial parent? _____

Please list all brothers, sisters, half-brothers/sisters, step-brothers/sisters. List their current age, sex, marital status, and occupation: _____

_____

_____

EDUCATION HISTORY:

Number of years completed: _____ Did you graduate? _____

If you dropped out before completing education, please explain: _____

How well did you do with your studies? Please explain: _____

How well did you get along with authorities? Please explain: _____

_____

How well did you get along with school mates, friends, and siblings? _____

_____

EMPLOYMENT HISTORY:

Please list all employment from high school to present. _____

_____

_____

_____

Please circle all forms of income received on a regular basis:

Employment Social Security Welfare Workman's Comp. Unemployment Other

Are you having any problems with your current job? If yes, please explain: _____

_____

_____

MILITARY HISTORY:

Have you ever served on active duty in the U.S. Military Service or National Guard / Reserves? _____

Branch:_____ Dates of Service: _____Highest Rank Attained: _____
Type of Discharge: _____ Are you receiving service disability? _____
Article 15's or court-martials while in the service?_____

MARITAL / FAMILY HISTORY:

Current Marital Status. Please circle all that apply:

Married Separated Living Together Divorced Never Married Widowed Remarried

How many times have you been married? _____

Please list below the dates of each marriage, reasons for marriage ending, and the number of children resulting from each: _____

_____

Current Spouse's Name:_____Age: _____

Spouse's Occupation:_____Spouse's Education Level: _____

In the space below, please list all of your children in order of birth. Please note if they are deceased with cause of death. If they are currently in school, please list name of school and grade. _____

_____

Have you ever experienced any difficulty with any of your children? _____

_____

LEGAL HISTORY:

Please answer the following questions:

Have you been convicted or charged with a DUI / DWI?	Yes ____	No ____
Have you been charged and/or convicted of any crime?	Yes ____	No ____
Do you have any current court action pending?	Yes ____	No ____
Are you currently on probation?	Yes ____	No ____
Have you served time in a penitentiary or jail?	Yes ____	No ____

If you have answered yes to any of the questions above, please explain: _____

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