sunny days therapeutics

Medical and Mental Health History Form

Do you give us permission for regular on-going updates to your primary care physician?_____

Name:_____ Date: _____
Date of Birth:_____ Primary Care Physician: _____

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

☐ Racing thoughts	☐ Decreased need for sleep	☐ Suspiciousness
☐ Impulsivity	☐ Excessive worry	☐ Excessive guilt
☐ Increased risky behavior	☐ Anxiety attacks	☐ Increased irritability
☐ Increased libido	☐ Avoidance	☐ Excessive energy
☐ Decreased libido	☐ Hallucinations	☐ Crying spells

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?	☐ YES	☐ NO
When was the last time you had thoughts of dying?	☐ YES	☐ NO
Has anything happened recently to make you feel this way?	☐ YES	☐ NO
Have you had recent thoughts of suicide?	☐ YES	☐ NO
If Yes, do you have a plan?	☐ YES	☐ NO
Is there anything that would stop you from killing yourself?	☐ YES	☐ NO

Depression Screen

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	NOT AT ALL	SEVERAL DAYS	MORE THAN SEVERAL DAYS	NEARLY EVERYDAY
Little interest or pleasure in doing things	☐	☐	☐	☐
Feeling down, depressed, or hopeless	☐	☐	☐	☐
Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
Feeling tired or having little energy	☐	☐	☐	☐
Poor appetite or overeating	☐	☐	☐	☐
Feeling bad about yourself, or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
Trouble concentrating on things such as reading the newspaper or watching television	☐	☐	☐	☐
Moving or speaking so slowly that other people could have noticed? Or the opposite---being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐

- How difficult have these problems made it for you to do your work, take care of things at home or get along with other people? (please check one)

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

Anxiety Screen

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	NOT AT ALL	SEVERAL DAYS	MORE THAN SEVERAL DAYS	NEARLY EVERYDAY
Feeling nervous, anxious or on edge	☐	☐	☐	☐
Not being able to stop or control worrying	☐	☐	☐	☐
Worrying too much about different things	☐	☐	☐	☐
Troubling relaxing	☐	☐	☐	☐
Being so restless that it is hard to sit still	☐	☐	☐	☐
Becoming easily annoyed or irritable	☐	☐	☐	☐
Feeling afraid as if something awful might happen	☐	☐	☐	☐

I have been exposed to actual or threatened death, serious injury or sexual violence.	☐ YES	☐ NO
I have intense memories of a previous traumatic event.	☐ YES	☐ NO
I try to avoid people, places or things associated with a traumatic event	☐ YES	☐ NO
My thoughts and moods have been negatively impacted by a traumatic event.	☐ YES	☐ NO
I feel numb, detached or isolated from others.	☐ YES	☐ NO
I have mood swings that seem to come out of nowhere	☐ YES	☐ NO

List ALL current prescription medications and how often you take them, (if none, write none)

Medication	Dose	When Started

Current over-the-counter medications/supplements/vitamins:

Trauma History:

Do you have a history of being abused emotionally, sexually, physically or by neglect? ■ YES ☐ NO

Please describe when, where, and by whom:

Legal History:

Have you ever been arrested?	☐ YES	☐ NO
Do you have any pending legal problems?	☐ YES	☐ NO

Past Psychiatric History:

Outpatient treatment?	☒ YES	☐ NO

If yes, please describe below:

Reason	**Dates**

Past Psychiatric History:

Psychiatric Hospitalization	☐ YES	☐ NO

If yes, please describe below:

Reason	**Dates**

Past Psychiatric Medications: If you have ever taken any of the following medications, please state if they were helpful, and any side effects you remember (it is ok if you do not remember all aspects, please fill in what you can).

Antidepressants:

	WHEN	DOSE	SIDE EFFECTS
Prozac (fluoxetine)			
Zoloft (sertraline)			
Luvox (fluvoxamine)			
Paxil(paroxetine)			
Celexa(citalopram)			
Lexapro(escitalopram			
Effexor (venlafaxine)			
Cymbalta(duloxetine)			
Wellbutrin (bupropion)			
Remeron (mirtazapine)			
Other			

Mood Stabilizers:

	WHEN	DOSE	SIDE EFFECTS
Tegretol(carbamazepine)			
Lithium			
Depakote (valproate)			
Lamictal(lamotrigine)			
Topamax(topiramate)			
Lexapro(escitalopram			
Other:			

Antipsychotics/Mood Stabilizers:

	WHEN	DOSE	SIDE EFFECTS
Abilify (aripiprazole)			
Risperdal (risperidone			
Seroquel (quetiapine)			
Zyprexa(olanzapine)			
Geodon(ziprasidone)			
Clozaril(clozapine)			
Haldol(haloperidol)			
Prolixin(fluphenazine)			
Other:			

Sleep Medications:

	WHEN	DOSE	SIDE EFFECTS
Ambien(zolpidem)			
Sonata(zaleplon)			
Rozerem(ramelteon)			
Restoril(temazepam)			
Desyrel(trazodone)			
Other:			

ADHD medications

	WHEN	DOSE	SIDE EFFECTS
Adderall(amphetamine)			
Concerta(methylphenidate)			
Ritalin(methylphenidate)			
Strattera(atomoxetine)			
Other:			

Anti-Anxiety medications:

	WHEN	DOSE	SIDE EFFECTS
Xanax (alprazolam)			
Ativan(lorazepam)			
Klonopin(clonazepam)			
Valium(diazepam)			
Tranxene(clorazepate)			
Buspar(buspirone)			
Other:			

Family Psychiatric History: Has anyone in your family been diagnosed with or treated for:

- ☐ Bipolar disorder
- ☐ Schizophrenia
- ☐ Depression
- ☐ Post-traumatic stress
- ☐ Anxiety
- ☐ Alcohol abuse
- ☐ Violence
- ☐ Anger
- ☐ Other substance abuse
- ☐ Suicide

Substance Use:

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 or abuse?	☐ **YES**	☐ **NO**

If yes, for which substances?

If yes, where were you treated and when?

Check if you have ever tried the following:

☐ Cocaine	☐ Stimulants (pills)	☐ Heroin	☐ Marijuana
☐ Methamphetamine	☐ Pain killers (not as prescribed)	☐ Methadone	☐ Sleeping pills
☐ Alcohol	☐ Ecstasy	☐ Other :_____	

How many caffeinated beverages do you drink a day?

☐ **Coffee**	
☐ **Sodas**	
☐ **Tea**	
☐ **Energy Drinks**	

Have you ever smoked cigarettes?

CURRENTLY? ☐ YES ☐ NO

IN THE PAST? ☐ YES ☐ NO

How many packs per day on average?_____ When did you quit? _____

How many years?_____

Pipe, cigars, or chewing tobacco:

CURRENTLY? ☐ YES ☐ NO

IN THE PAST? ☐ YES ☐ NO

What kind?_____ How many years?_____

How often per day on average?_____

Family Background and Childhood

History:
Where did you grow up?_____

List your siblings and their ages:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Has anyone in your immediate family died?

_____
_____
_____
_____

Past Medical History:

Allergies:
_____
_____
_____

Current Weight:_____ Height:_____

Current Medical
Problems:_____
_____
_____
_____

Past medical problems, including surgeries and prolonged hospital stays:
_____
_____
_____
_____
_____

Your Exercise Level:

Do you exercise regularly? ☐ YES ☐ NO

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 (If applicable)_____ How many times have you been pregnant?___ How many live births?___

Personal and Family Medical History:

Yourself:

- ☐ Thyroid Disease
- ☐ Anemia
- ☐ Liver Disease
- ☐ Chronic Fatigue
- ☐ Kidney Disease
- ☐ Diabetes
- ☐ Asthma/respiratory problems
- ☐ Stomach or intestinal problems
- ☐ Cancer (type)
- ☐ Fibromyalgia
- ☐ Heart Disease
- ☐ Epilepsy or seizures
- ☐ Chronic Pain
- ☐ High Cholesterol
- ☐ High blood pressure
- ☐ Head trauma
- ☐ Liver problems
- ☐ Other _____

Family:

- ☐ Thyroid Disease
- ☐ Anemia
- ☐ Liver Disease
- ☐ Chronic Fatigue
- ☐ Kidney Disease
- ☐ Diabetes
- ☐ Asthma/respiratory problems
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- ☐ Epilepsy or seizures
- ☐ Chronic Pain
- ☐ High Cholesterol
- ☐ High blood pressure
- ☐ Head trauma
- ☐ Liver problems
- ☐ Other _____

Educational History:

Highest Grade completed?_____

Did you attend college? ☐ YES ☐ NO

Where:_____ Major?:_____

Occupational History:

Are you currently:

☐ Working ☐ Student ☐ Unemployed ☐ Retired ☐ How long in present position? _____

What is/was your occupation?:_____

Where do you work?_____

Have you ever served in the military?_____

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?_____

Are you sexually active? ☐ YES ☐ NO

How would you identify your sexual orientation?

☐ straight/heterosexual ☐ lesbian/gay/homosexual ☐ bisexual ☐ transgender

☐ 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?_____

Do you have children? ☒ YES ☐ NO

If yes, list ages and gender:

List everyone who currently lives with you:

Spiritual Life:

Do you belong to a particular religion or spiritual group? ☒ YES ☐ NO

Do you find your involvement helpful during this illness, or does the involvement make things:

☐ Stressful ☐ More helpful

Other comments or concerns:

Signature:_____ Date:_____

Emergency Contact:_____ Telephone:_____