STONE OAK CHILD AND ADOLESCENT PSYCHIATRY

Name: **Age:** **Date:**

Please answer the following questions to the best of your ability, realizing that true and accurate answers are important to the delivery of quality care.

Marital Status

[] Single []Married _____years []Divorced ____years []Widowed ____years []Separated _____years []Other:

Household

Current living situation: Do you live alone: [ ] Yes [ ] No If no, who else lives with you:

If minor child, do both parents live in same household: [ ] Yes [ ] No

If not both biological parents are required to be present for the session.

Do you have children: [ ]Yes [ ]No

If yes, how many children and what are the ages:

Academic/Employment History

Education	Highest grade completed:
Work History	Occupation:
	How long have you been employed:
Hobbies Things you enjoy doing:	

What are your goals/expectations for treatment?

Past Psychiatric Treatment

Have you ever been hospitalized for psychiatric reasons: [ ]Yes [ ]No

If yes, when and where:

Have you ever had outpatient treatment by a psychiatrist: [ ]Yes [ ]No

If yes, when and where:

What was the diagnosis of your past psychiatric treatment?

Which *psychiatric medications* have you taken in the past and what were the benefits and/or side effects?

Current Medication List

Medication	Dose	Frequency

Are you allergic to any medications: [ ]Yes [ ]No If yes list medications and allergic reactions:

Have you undergone any surgical procedures: [ ]Yes [ ]No If yes, please list procedures and dates of surgery
Family Medical History- Please list diagnosis and biological family relation:
Family Psychiatric History- Please list diagnosis and biological family relation:
Have you ever suffered a severe head injury with loss of consciousness or concussion: [ ]Yes [ ]No
Describe:
Do you often worry or feel nervous: [ ]Yes [ ]No
How many hours do you sleep per night: [ ]1-3 [ ]4-6 [ ]7-10
How many meals do you eat per day: [ ]1 [ ]2 [ ]3 [ ]4

What bothers you the most

[ ] Problems/losses within my family	[ ]Housing problems	[ ]Discipline problems at work
[ ] Problems/losses among my friends	[ ] Occupational Problems	[ ]Problems with law, legar system
[ ] Can't get adequate health care	[ ] Financial/ economic problems	[ ]Carless, high risk behavior

Past Medical History

[ ]Diabetes	[ ]Heart Disease	[ ]Blood Pressure	[ ]Vertigo/Dizziness	[ ]Pace Maker Implant
[ ]Asthma	[ ]Emphysema	[ ]Liver disease	[ ]Arthritis	[ ]Emphysema
[ ]Depression	[ ]Anxiety	[ ]Ulcers	[ ]Tremors	[ ]Tuberculosis
[ ]Stroke	[ ]Heart Palpation	[ ]Heart Surgery	[ ]Kidney Disease	[ ]Fainting
[ ]Cancer	[ ]Lung Disease	[ ]Pneumonia	[ ]Motor Difficulties	[ ]Recurring headaches
[ ]Chronic Cough	[ ]Bronchitis	[ ]Difficulty Walking	[ ]Muscle Cramps	[ ]Weakness
[ ]Shortness of breath	[ ]Seizure	[ ]Serious Head Injury	[ ]Numbness	[ ]Uncontrolled movements
[ ]Hormone problems	[ ]Epilepsy	[ ]Muscle Stiffness	[ ]Thyroid disease	[ ]Blood Disease
[ ]Heart Attack	[ ]None	[ ]Other		

Substance Abuse

Alcohol: [ ]Yes [ ]No	Age first used:	Last use:	Frequency:	Amount:
Tobacco: [ ]Yes [ ]No	Age first used:	Last use:	Frequency:	Amount:
Cannabis: [ ]Yes [ ]No	Age first used:	Last use:	Frequency:	Amount:
Hallucinogens: [ ]Yes [ ]No	Age first used:	Last use:	Frequency:	Amount:
IV Drugs: [ ]Yes [ ]No	Age first used:	Last use:	Frequency:	Amount:
Other Illicit Drug Use: [ ] Yes [ ] No	Type			
	Age first used:	Last use:	Frequency:	Amount:

Sexual History

Are you sexually active: [ ]Yes [ ]No Sexual Orientation:

How many partners in the past year: [ ]0 [ ]1 [ ]2-3 [ ]4-10 [ ]more than 10

Are you using protection: [ ]Yes [ ]No Type of protection:

Have you ever had a sexually transmitted disease: [ ]Yes [ ]No

Any problems with sexual function: [ ]Yes [ ]No

Have you had a recent break up: [ ]Yes [ ]No

Abuse/Trauma History	
Physical Abuse: [ ]Yes [ ]NO Was it reported: [ ]Yes [ ]NO	How old were you: By who:
Emotional Abuse: [ ]Yes [ ]NO Was it reported: [ ]Yes [ ]NO	How old were you: By who:
Verbal Abuse: [ ]Yes [ ]NO Was it reported: [ ]Yes [ ]NO	How old were you: By who:
Sexual Abuse: [ ]Yes [ ]NO Was it reported: [ ]Yes [ ]NO	How old were you: By who:
Bullying: [ ]Yes [ ]NO Was it reported: [ ]Yes [ ]NO	How old were you: By who:
Other Traumas: [ ]Yes [ ]NO *(motor vehicle accidents, death of a loved one, etc.)*	

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Legal History	
Legal : [ ]Yes [ ]NO Past or current charges/lawsuits	
History of probation [ ]Yes [ ]NO	For how long: Is it Completed:
History of DWI : [ ]Yes [ ]NO	Details:
History of MIP: [ ]Yes [ ]NO	Details:

Social History

Where were you born:

Where did you grow up:

Did your parents stay together while you were growing up: [ ]Yes [ ]No

If no, how old were you when they separated/divorced:

Father's occupation while you were growing up:

Mother's occupation while you were growing up:

Were there any complications at you birth: [ ]Yes [ ]No (premature birth, major medical problems)

Describe:

Any problems with developmental Milestones: [ ]Yes [ ]No

Describe:

Childhood History

How was your childhood:

Were you close to your family members:

Did you grow up in an emotionally nurturing household: [ ]Yes [ ]No

Do you have siblings: [ ]Yes [ ]No How many brothers: How many sisters:

Please list ages of siblings from oldest to youngest:
