STONE OAK PSYCHIATRY

Social and Childhood History

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:

_____

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 affects?

List:_____

_____

Current Medication List

Medication	Dose	Frequency

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Are you allergic to any medications: [ ]Yes [ ]No
List medications and allergic reactions:_____

_____

_____

Have you undergone any surgical procedures: [ ]Yes [ ]No
Please list procedures and dates of surgery:_____

_____

_____

_____

Family Medical History- Please list diagnosis and 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 are things that bother you the most.

[ ] Problems/losses within my family	[ ]Problems/losses among my friends community
[ ] Educational problems	[ ] Occupational Problems
[ ] Housing Problems	[ ] Financial/ economic problems
[ ] Can't get adequate health care	[ ] Problems with law, legal system
[ ] Discipline problems at work	[ ] Careless, high-risk behavior
[ ] Other:_____	

Past Medical History

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

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Substance Use				
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	Age first used: Type:	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

If yes, 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	How old were you: _____ By who:_____ Was it reported: [ ] Yes [ ] No
Emotional Abuse: [ ] Yes [ ] No	How old were you: _____ By who:_____ Was it reported: [ ] Yes [ ] No

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Verbal Abuse: [ ] Yes [ ] No	How old were you: _____ By who:_____ Was it reported: [ ] Yes [ ] No
Sexual Abuse: [ ] Yes [ ] No	How old were you:_____ By who:_____ Was it reported: [ ] Yes [ ] No
Bullying: [ ] Yes [ ] No	How old were you: _____ By who:_____ Was it reported: [ ] Yes [ ] No
Other Traumas: [ ] Yes [ ] No	*(e.g., motor vehicle accidents, death of a loved one)* Details:_____
Legal History	
Legal : [ ] Yes [ ] No	*Past or Current Charges/ Lawsuits:* Describe:
History of Probation: [ ] Yes [ ] No	For how long: _____ Is it completed: [ ]Yes [ ]No
History of DWI: [ ] Yes [ ] No	Details:
History of MIP: [ ] Yes [ ] No	Details:

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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:_____

_____

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

Describe:_____

_____

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

If yes, please explain: _____

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 siblings:_____Brothers _____Sisters

List ages of siblings from oldest to youngest
