Brain Solutions

Patient: _____

DOB: _____ **ID:** _____

Patient History Form

Name: _____ Date: ____/____/____ DOB: ____/____/____
Last First M.I

Home Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____ **SSN:** _____ Sex: ❑ F ❑ M

Height: _____ **Weight:** _____ How did you hear about Brain Solutions? _____

Transportation: If you use a service, Service Name: _____ Phone #: _____

Please check present symptoms:

- ❑ Sleep
- ❑ Appetite
- ❑ Depression
- ❑ Anxiety
- ❑ Panic: SOB
- ❑ Panic: Palpitations
- ❑ Panic: Dizziness
- ❑ Panic: Dread Paresthesia
- ❑ Irritability/Rage
- ❑ Racing Thoughts
- ❑ Concentration
- ❑ Motivation
- ❑ Interests
- ❑ Energy
- ❑ Guilty thoughts
- ❑ Hopelessness
- ❑ OCD
- ❑ Auditory Hallucinations
- ❑ Visual Hallucinations
- ❑ Delusions
- ❑ Self harm thoughts
- ❑ Homicidal thoughts
- ❑ Intent to harm
- ❑ Plan to harm
- ❑ Alcohol/Drug Use
- ❑ Other (please specify):

_____

_____

Previous Psychiatric Hospitalizations and Outpatient Treatments (when, where, and for what reason):

_____

_____

Previous suicide attempts or self-injurious behaviors (type, date):

_____

_____

Have you ever had psychotherapy? ❑Yes ❑No If yes, was it helpful? Please explain: _____

Please check if you have been diagnosed with any of these psychiatric or mental health disorders:

- ❑ Depression
- ❑ Bipolar Disorder
- ❑ Anxiety
- ❑ Panic Attacks
- ❑ Social anxiety
- ❑ Stress Disorder
- ❑ Anorexia
- ❑ Bulimia
- ❑ Addiction of any kind
  - ❑ Gambling
  - ❑ Alcohol or drug
  - ❑ Sex
  - ❑ Computer gaming
  - ❑ Other: _____
- ❑ Schizophrenia
- ❑ Schizoaffective
- ❑ Psychosis
- ❑ Attention Deficit/Hyperactivity Disorder (ADHD)
- ❑ Learning Disorder
- ❑ Dementia
- ❑ Traumatic Brain Injury (TBI)
- ❑ Other (Please specify):

_____

Current Medication

Pharmacy Name: _____ Pharmacy Address: _____

Phone: _____ Fax: _____

Drug allergies? ❑Yes ❑No If yes, please specify: _____

Please list any medications you are now taking. Include dose, quantity, non-prescription medications, and vitamins/supplements:

_____

_____

_____

_____

Medication History

Please check the psychiatric medication that you have taken in the past:

- ❑ Abilify-aripiprazole
- ❑ Adderall-amphetamine
- ❑ Ambien-zolpidem
- ❑ Aricept-donepezil
- ❑ Atarix-hydroxyzine
- ❑ Ativan-lorazepam
- ❑ Buspar-Buspirone
- ❑ Celexa-citalopram
- ❑ Clozaril-clozapine
- ❑ Cogentin-benztropine
- ❑ Cymbalta-duloxetine
- ❑ Depakote-divalproex
- ❑ Desyrel-trazadone
- ❑ Effexor-venlafazine
- ❑ Elavil-amitriptyline
- ❑ Exelon Patch
- ❑ Geodon-ziprasidone
- ❑ Haldol-haloproraldol
- ❑ Invega-paliperidone
- ❑ Klonopin-clonazepam
- ❑ Lamictal-lamotrigine
- ❑ Latuda-lurasidone
- ❑ Lexapro-escitalopran
- ❑ Lithium-eskalith
- ❑ Lunesta-eszopiclone
- ❑ Luvox-fluvoxamine
- ❑ Namenda-memantine
- ❑ Neurontra- gabapentin
- ❑ Pamelor-nortriptyline
- ❑ Prozac-flouxetine
- ❑ Paxzil-Parozetine
- ❑ Remeron-mirtazapine
- ❑ Ritalin-methylphenidate
- ❑ Rozerem-reamelteon
- ❑ Risperdal-risperidone
- ❑ Seroquel-quetiapine
- ❑ Sonata-zaleplon
- ❑ Tegretol- carbamazepine
- ❑ Trazodone
- ❑ Trilafon-perphenazine
- ❑ Valium-diazepam
- ❑ Viibryd-vilazodone
- ❑ Vyvanse-lisdexamfetamine
- ❑ Wellbutrin-buproprion
- ❑ Xanax-alprazolam
- ❑ Zoloft-sertraline
- ❑ Zyprexa-olanzapine
- ❑ Other:_____

Past Medical History

Do you now or have you ever had:

- ❑ Diabetes
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Hypothyroidism
- ❑ Goiter
- ❑ Cancer (type):

  _____
- ❑ Leukemia
- ❑ Psoriasis
- ❑ Angina
- ❑ Heart problems
- ❑ Heart murmur
- ❑ Pneumonia
- ❑ Pulmonary embolism
- ❑ Asthma
- ❑ Emphysema
- ❑ Stroke
- ❑ Epilepsy (seizures)
- ❑ Cataracts
- ❑ Kidney disease
- ❑ Kidney stones
- ❑ Crohn's disease
- ❑ Colitis
- ❑ Anemia
- ❑ Jaundice
- ❑ Hepatitis
- ❑ Stomach/peptic ulcer
- ❑ Rheumatic fever
- ❑ Tuberculosis
- ❑ HIV/AIDS
- ❑ Arthritis
- ❑ Head Injury
- ❑ Other Seizures

Women's Reproductive History

Do you have regular periods? ❑Yes ❑No Age of first period: _____

Have you reached menopause? ❑Yes ❑No If yes, at what age? _____ Number of:

Pregnancies	Miscarriages	Abortions

Personal History

Were there problems with your birth? ❑Yes ❑No If yes, please specify: _____

Where were you born and raised? _____

What is your highest education? ❑High School ❑Some college ❑College graduate ❑Advanced degree

Marital status: ❑Never married ❑Married ❑Divorced ❑Separated ❑Widowed ❑Partnered/significant other

Are you working? ❑Yes ❑No

If yes, what is your current occupation? _____ Hours/week: _____

If no, what is your past occupation and reason for leaving? _____

Religion/Spirituality: _____

Do you receive disability or SSI? ❑Yes ❑No If yes, for what disability and how long? _____

Have you ever had legal problems? ❑Yes ❑No If yes, please specify: _____

Have you ever been arrested for a DUI? ❑Yes ❑No

Past Personal Treatment History

Check all that apply (please specify age[s]):

- ❑ Outpatient: _____
- ❑ Inpatient: _____
- ❑ IOP (Intensive Outpatient): _____
- ❑ Substance Abuse 12-step program: _____
- ❑ Stopped on own: _____
- ❑ Other (specify): _____

Personal substances used/abused (complete all that apply):

	First Use Age	Frequency	Amount	Current Use	Last Use Age
Tobacco/cigarettes/nicotine					
Amphetamines/speed					
Cannabis/MJ/THC					
Heroin/opiates/pain meds					
Cocaine					
Crack cocaine					
Alcohol					
Inhalants (e.g. glue, gas, etc)					
Other: _____					

Consequences of substance abuse (check all that apply):

- ❑ Hangovers
- ❑ Seizures
- ❑ Blackouts
- ❑ Overdose
- ❑ Withdrawal symptoms
- ❑ Medical conditions
- ❑ Tolerance changes
- ❑ Loss of control amount used
- ❑ Sleep disturbance
- ❑ Assaults
- ❑ Suicidal impulse
- ❑ Relationship conflicts
- ❑ Binges
- ❑ Job loss
- ❑ Arrests
- ❑ Other:_____

Family History

	Age(s)	Medical	Psychiatric	Substance abuse	Age and Cause of death
Grandfather *Maternal/Paternal					
Grandmother *Maternal/Paternal					
Mother					
Father					
Uncle					
Aunt					
Sibling(s)					
Children					

*Please circle one

Systems Review

In the past month, have you had any of the following problems?

GENERAL
- ❑ Recent weight gain; how much:
- ❑ Recent weight loss; how much:
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever
- ❑ Night sweats

EARS
- ❑ Ringing in ears
- ❑ Loss of hearing

EYES
- ❑ Pain
- ❑ Redness
- ❑ Loss of vision
- ❑ Double or blurred vision
- ❑ Dryness

SKIN
- ❑ Redness
- ❑ Rash
- ❑ Nodules/bumps
- ❑ Hair loss
- ❑ Color changes of hands or feet

THROAT
- ❑ Frequent sore throat
- ❑ Hoarseness
- ❑ Difficulty swallowing
- ❑ Pain in jaw

BLOOD
- ❑ Anemia
- ❑ Clots

NERVOUS SYSTEM
- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting/loss of consciousness
- ❑ Numbness or tingling
- ❑ Memory loss

STOMACH AND INTESTINES
- ❑ Nausea
- ❑ Heartburn
- ❑ Stomach pain
- ❑ Vomiting
- ❑ Yellow jaundice
- ❑ increasing constipation
- ❑ Persistent diarrhea
- ❑ Blood in stools
- ❑ Black stools

HEART AND LUNGS
- ❑ Chest pain
- ❑ Palpitations
- ❑ Shortness of breath
- ❑ Swollen legs or feet
- ❑ Cough

MUSCLE/JOINTS/BONES
- ❑ Numbness
- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Joint swelling (where):

KIDNEY/URINE/BLADDER
- ❑ Frequent or painful urination
- ❑ Blood in urine

WOMAN ONLY
- ❑ Abnormal pap smear
- ❑ Irregular periods
- ❑ Bleeding between periods
- ❑ PMS

PSYCHIATRIC
- ❑ Depression
- ❑ Excessive worries
- ❑ Difficulty falling asleep
- ❑ Difficulty staying asleep
- ❑ Difficulties with sexual arousal
- ❑ Poor appetite
- ❑ Food cravings
- ❑ Frequent crying
- ❑ Sensitivity
- ❑ Thoughts of suicide/attempts
- ❑ Stress
- ❑ Irritability
- ❑ Poor concentration
- ❑ Guilty thoughts
- ❑ Hallucinations
- ❑ Rapid speech
- ❑ Racing thoughts
- ❑ Paranoia
- ❑ Mood swings
- ❑ Anxiety
- ❑ Risky behavior

OTHER PROBLEMS

_____

Please list any additional concerns or information helpful to your treatment:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Patient Health Questionnaire (PHQ-9)

Name: _____

Date: _____

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

(Please Circle to indicate your answer)	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. 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	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

If you checked off any problems, 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?

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

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