Stonebriar Psychiatric Services, PA
Medical and Social History

Name: _____ Age: _____ M ____ F ____ Date: _____ DOB_____

Address: _____ City:_____ Zip:_____

SS # _____ Home Phone: _____ Work phone: _____

Cell phone: _____ E-mail Address: _____

Emergency contact Name/Relationship/Number _____

How did you hear about our office: _____

Primary Care Physician/Address:_____

_____

Date of Last Physical: _____

HISTORY OF PAST ILLNESS: Have you had

Childhood

☐ Measles ☐ Rheumatic fever or heart disease
☐ Congenital Abnormalities ☐ Mumps ☐ Chicken Pox

Adult:

☐ Asthma ☐ High Blood Pressure ☐ Cancer (Site _____)
☐ Diabetes ☐ Ulcer or Gastritis ☐ Thyroid Problems
☐ Tuberculosis ☐ Kidney Problem ☐ Liver Problem
☐ Blood Problem ☐ Venereal Disease ☐ Heart Failure
☐ Heart Attack ☐ Abnormal Heart Rhythm
☐ Osteopenia/osteoporosis

OPERATIONS:

Have you ever had any surgery? ☐ yes ☐ no
If yes, what type and when:

_____
_____
_____

ALLERGIES:

_____
_____

CURRENT MEDICATIONS:

_____
_____
_____
_____
_____
_____

INJURIES:

Have you ever been in a serious motor vehicle accident? ☐yes ☐no
Have you had any head concussions or injuries? ☐ yes ☐ no
Have you ever been knocked unconscious? ☐ yes ☐ no

PAST PSYCHIATRIC HISTORY:

List all therapists, counselors and hospitalizations (with dates)

_____
_____
_____
_____
_____
_____
_____
_____

SOCIAL HISTORY:

Circle One: Single Married Separated
Divorced Widowed Significant Other

With whom do you live? _____

History of Drug Usage? ☐ yes ☐ no
Do you have concerns regarding sexual function? ☐ yes ☐ no
Foreign Travel within the past year_____

Coffee _____ Tea _____ Colas _____ per day

Alcohol ☐ Never ☐ < 1 per week ☐ 1-5 per week ☐ Other

Tobacco: ☐ Never smoked ☐ Quit _____ years ago
☐ Packs per day ☐ Years smoked _____

SOCIAL HISTORY: (continued)

Are you employed? ☐ Full Time ☐ Part Time

What is your job? _____

_____

Are you a student? ☐ yes ☐ no If so, where_____
How much time have you lost from work or school because of your health during the past: Six months _____ One year _____
5 Years _____
Education: (Years)
Grade School _____ College _____ Postgraduate _____
Do you wear seatbelts? ☐ Always ☐ Sometimes ☐ Never

FAMILY HISTORY	**AGE**	**HEALTH**	If Deceased, Age @ Death	Cause of Death
Father				
Mother				
Brother/Sister				
Husband/Wife				
Son/Daughter				

Has either parent, sister, brother, child or grandparent ever had psychiatric problems, substance abuse, or treatment? If so, what type of illness and treatment _____

_____

_____

Has any blood relative had diabetes ☐ Yes ☐ No
Has any blood relative ever attempted or completed suicide?
☐ Yes ☐ No

SYSTEMIC REVIEW:
WEIGHT: Current _____ Max. _____ Min _____
Recent weight change? ☐ Yes ☐ No

Height _____ Neck Circumference: _____ inches

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Have you recently had: ☐ Weakness ☐ Fever ☐ Chills
☐ Fainting ☐ Problems Sleeping ☐ Night Sweats

CIRCLE if you have had the following:

SKIN
Skin Disease ……..Yes No
Jaundice …… .Yes No
Hives, eczema, rash……..……Yes No

Head-Eyes-Ears-Nose-Throat

Dry eyes or mouth …….. Yes No
Bleeding gums – frequent or consistent ……..… Yes No
Blurred vision…..……..... Yes No
Date of last eye exam _____
Nosebleeds – frequent …….. Yes No
Chronic sinus trouble …… Yes No
Ear disease …… Yes No
Impaired hearing …….. Yes No
Dizziness or sensation of room spinning …… Yes No
Frequent or severe headaches …….. Yes No

Respiratory
Asthma or Wheezing …… Yes No
Difficulty breathing …….. Yes No
Pleurisy or Pneumonia …… Yes No
Cough up Blood (ever) …… Yes No

Cardiovascular
Chest pain, pressure or tightness ……..… Yes No
Shortness of breath with walking or lying down ……. Yes No
Palpitations …… Yes No
Swelling of hands, feet or ankles …… Yes No
Awakening in the nights feeling smothered …….. Yes No
Heart murmur …….. Yes No

Gastrointestinal
Vomiting blood or food …….. Yes No
Gallbladder disease …… Yes No
Change in appetite …….. Yes No
Hepatitis / Jaundice …… Yes No
Painful bowel movements …… Yes No
Bleeding with bowel movements …… Yes No
Black stools …….. Yes No
Recent change in bowel habits …… Yes No
Frequent diarrhea …….. Yes No
Heartburn or indigestion …….. Yes No
Cramping or pain in the abdomen …… Yes No
Does food stick in throat …….. Yes No

Endocrine
Hormone therapy …….. Yes No
Any change in hat or glove size …… Yes No
Any change in hair growth …… Yes No
Have you become colder than before or skin dryer ……....Yes No

Neck
Stiffness ……..…… Yes No
Enlarged glands …… Yes No

Genitourinary:

Loss of urine …… Yes No
Blood in urine ……Yes No
Frequent urination …… Yes No
Burning or painful urination …… Yes No
Bedwetting ……. …….. Yes No
Kidney trouble …….. Yes No
Testicular mass ……..Yes No
Prostate problem ……Yes No
Sexual dysfunction …… Yes No
STD / AIDS risk …… Yes No

Gynecological:

First day of last period _____
Age periods started _____
How long do periods last _____
Frequency of periods every _____
Pain with periods …….. Yes No
Number of pregnancies _____
Number of miscarriages _____
Date of last cancer smear and results _____
Breast lump or discharge……Yes No
Abnormal vaginal discharge ……..Yes No
Pain with intercourse ……Yes No

Locomotor-musculoskeletal

Stiffness or pain in joints……Yes No
Weakness of muscles or joints …….. Yes No
Any difficulty walking …….. Yes No
Any pain in calves/buttocks with walking relieved w/rest …Yes No

Neuro-Psychiatric

☐ Transient blindness ☐ Tremor ☐ Weakness ☐ Fingers numb
Have you ever had counseling for mental health …….. Yes No
Have you ever been advised to see a psychiatrist …… Yes No
Have you or do you ever have fainting spells ……Yes No
Convulsions……Yes No
Paralysis ……Yes No
Problems with coordination ……Yes No
History of being physically or sexually abused ……..Yes No
Depression symptoms (difficulty sleeping, loss of appetite,
loss of interest in activities, feeling hopeless …… Yes No
History of ADHD …… Yes No
History of mood swings or bipolar illness …… Yes No
History of bingeing or purging ……..Yes No

Hematologic

Are you slow to heal after cuts …… Yes No
Anemia …….. Yes No
Phlebitis or blood clots in veins …… Yes No
Have you had difficulty with bleeding excessively
after tooth extraction or surgery? …… Yes No
Have you had abnormal bruising or bleeding …….. Yes No

Other

Do you snore loud enough to be heard through a closed door? Yes No
Do you often feel tired, fatigued during the day? …… Yes No
Has anyone observed you stop breathing during sleep?..... Yes No
Do you have/are you being treated for high blood pressure? Yes No

The information provided herein is accurate to the best of my knowledge. I understand it is my responsibility to inform my doctor of any changes in this information.

Patient signature: _____ Date: _____ Provider: _____

Signature of person providing this information: _____

Stonebriar Psychiatric Services, P.A.

Name: _____ Date: _____

Date of Birth: _____ Social Security #: _____

Home Address: _____ City, State, Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

May we leave messages at home? ❑ Yes ❑ No

May we leave messages at work? ❑ Yes ❑ No

May we send mail to you at this address? ❑ Yes ❑ No

Marital Status: ❑ S ❑ M ❑ D ❑ W Date of Current Marriage/Separation: _____

Number of Marriages: _____

Spouse's Name: _____ Date of Birth: _____

Child(ren)'s Name(s): _____ Date of Birth: _____ ❑ M ❑ F

_____ Date of Birth: _____ ❑ M ❑ F

_____ Date of Birth: _____ ❑ M ❑ F

Previously Married? ❑ Yes ❑ No If yes, when? _____ How long? _____

Occupation: _____ Highest Level of Education: _____

COUNSELING AND PSYCHIATRIC HISTORY

Have you had previous counseling? ❑ Yes ❑ No If yes, when? _____

Name and location of counselor: _____

If yes, for what reason? _____

For how long? _____ Was it helpful? _____

Have you ever been diagnosed with or treated for any type of mental illness? ❑ Yes ❑ No If yes, which type? _____

_____

Has anyone in your family ever been diagnosed with or treated for any type of mental illness? ❑ Yes ❑ No

If yes, who and which type? _____

REASONS FOR SEEKING HELP

What concerns have brought you to counseling today? _____

_____

_____

_____

Which of the following are causing the most concern for you? Please check all that apply:

❑ Home ❑ Work ❑ Marriage ❑ Other Relationships ❑ God

When did your present concerns begin to be a problem for you? _____

What concerns about you have been identified by others? _____

_____

Please rate the severity of your present concerns on the following scale. Check one:

❑ Mild ❑ Moderate ❑ Severe ❑ Totally Incapacitating

Please indicate which of the following areas are currently problematic for you. Check all that apply:

- ❑ Blackouts or temporary loss of memory
- ❑ Insomnia (not being able to sleep)
- ❑ Loss of appetite/increased appetite
- ❑ Uncontrollable anxiety or worry
- ❑ Lacking self-confidence
- ❑ Feeling fat
- ❑ Eating and then vomiting to control weight
- ❑ Excessive use of alcohol
- ❑ Abuse of non-prescription drugs
- ❑ Getting into trouble at school/work
- ❑ Feeling inferior to others
- ❑ Under too much pressure and feeling stressed
- ❑ Feeling down or unhappy/depressed mood
- ❑ Excessive anxiety or worry
- ❑ Feeling lonely
- ❑ Suspicious feelings toward other people
- ❑ Afraid of being on your own
- ❑ Angry feelings
- ❑ Inability to concentrate while at school/work
- ❑ Crying spells
- ❑ Feeling "on top of the world"
- ❑ Nightmares
- ❑ Loss of interest in usual activities/lack of motivation
- ❑ Obsessions or compulsions with specific activities
- ❑ Inability to control thoughts
- ❑ Feeling trapped in rooms/buildings
- ❑ Hearing voices
- ❑ Feeling that people are "out to get you" or that you are being watched
- ❑ Angry outbursts
- ❑ Excessive fear of specific places or objects
- ❑ Difficulty making friends
- ❑ Difficulty maintaining friendships
- ❑ Feeling as if you'd be better off dead
- ❑ Feeling manipulated or controlled by others
- ❑ Difficulty making decisions

- ❑ Concerns about finances
- ❑ Feeling "numb" or cut off from emotions
- ❑ Concerns about physical health
- ❑ Concerns about emotional stability
- ❑ Tremors
- ❑ Delusions
- ❑ Loss of interest in sexual relationships
- ❑ Feeling sexually attracted to members of your own sex
- ❑ Feeling distant from God
- ❑ Hallucinations
- ❑ Hypersomnia (sleeping all the time)
- ❑ Not being able to say what you really think or feel

❑ Other: _____

_____

_____

What would you like to gain from counseling? _____

_____

How did you hear about us? _____

SPIRITUALITY

Do you believe in God? ❑ Yes ❑ No What is your religious preference? _____

Are you a member of a church? ❑ Yes ❑ No If yes, what church? _____

How much influence does your religion have on your day-to-day activity? ❑ A lot ❑ A moderate amount ❑ A little ❑ None

EMERGENCY CONTACT

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

Address: _____ City, State, Zip: _____

(Next of Kin – Other than Spouse)

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

Address: _____ City, State, Zip: _____