Southern Psychiatry

PRE-APPOINTMENT INFORMATION FORM (ADULT)

Full Name: _____ Preferred Name: _____

Date of Birth: _____ Age: _____ Today's Date: _____

Person Completing This Form (if not patient): _____

Primary Care Doctor: _____ Therapist: _____

What are your concerns leading to this evaluation: (please be as specific as possible)

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List of Medications

	Name of Medication	Dose and frequency	Reason
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Medication Allergies

Patient's Psychiatric History

Previous diagnoses and/or testing:

Past medications, dose, and reason:

Past hospitalizations:

Previous therapists:

Patient's Medical History
Has the patient ever been diagnosed with the following (circle all that apply):

Asthma	Diabetes	High Blood Pressure	High Cholesterol	Seizures
HIV	Thyroid	Hearing Problems	Vision Problems	Hypoglycemia
Birth Defect	Cancer	Genetic Syndrome	Head Trauma/Concussion/TBI	

Other:

Past surgeries:

Past significant hospitalizations (medical):

Alcohol and Drug Use History
Alcohol: Describe consumption history:

Have there been legal, medical, or school/work-related problems as a result?

Illicit substances:
Has the patient used or experimented with marijuana, cocaine, prescription medications, or other drugs? If so, please describe.

Have there been legal, medical, or school/work-related problems as a result?

Social History

Place of birth: Grew up in/hometown:

Raised by: Siblings:

Has the patient ever been a victim of or exposed to:

- Sexual abuse/molestation:
- Physical abuse:
- Emotional abuse:
- Domestic Violence:
- Other:

Educational level: Work history:

Marital Status: Children:

Family Mental Health History

Has any immediate or extended family member been diagnosed of the following (circle all that apply)?

Depression	Bipolar Disorder	OCD	Personality Disorder
Anxiety	PTSD	Panic Attacks	Learning Disorders
Psychosis	Schizophrenia	ADHD	Autism/Asperger's Disorder
Dementia	Suicide Attempts	Hallucinations	Intellectual Disability
Alcohol Related Problems		Drug Related Problems	

Other:

Which family members have been diagnosed or has had any of these problems?

Has anyone received mental health medications? If so, who and which medications?

Has anyone been hospitalized for mental health reasons?

Family Medical History

Does anyone in the family have any of the following medical problems (circle all that apply)?

Asthma	Diabetes	High Blood Pressure	High Cholesterol	Seizures
HIV	Thyroid	Hearing Problems	Vision Problems	Cancer
Birth Defect	Genetic Syndrome	Hypoglycemia	Head Trauma/Concussion/TBI	

Which family members have been diagnosed or has had any of these problems?

Patient Health Questionnaire-9 (PHQ-9)

Name: _____ **Date**: _____

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

Sum of Column _____+_____+_____+ _____

=Total Score: _____

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

Beck Anxiety Inventory

Name: _____ **Date**: _____

Below is a list of common symptoms of anxiety. Please carefully read each item in the list. Indicate how much you have been bothered by that symptom during the past month, including today, by circling the number in the corresponding space in the column next to each symptom.

	Not At All	Mildly but it didn't bother me much.	Moderately - it wasn't pleasant at times	Severely – it bothered me a lot
Numbness or tingling	0	1	2	3
Feeling hot	0	1	2	3
Wobbliness in legs	0	1	2	3
Unable to relax	0	1	2	3
Fear of worst happening	0	1	2	3
Dizzy or lightheaded	0	1	2	3
Heart pounding/racing	0	1	2	3
Unsteady	0	1	2	3
Terrified or afraid	0	1	2	3
Nervous	0	1	2	3
Feeling of choking	0	1	2	3
Hands trembling	0	1	2	3
Shaky / unsteady	0	1	2	3
Fear of losing control	0	1	2	3
Difficulty in breathing	0	1	2	3
Fear of dying	0	1	2	3
Scared	0	1	2	3
Indigestion	0	1	2	3
Faint / lightheaded	0	1	2	3
Face flushed	0	1	2	3
Hot/cold sweats	0	1	2	3
Column Sum				

Scoring - ***Sum each column. Then sum the column totals to achieve a grand score.***

Write that score here _____ .