SELF-INFORMATION SHEET

Name: _____ Age: _____

Last First Middle

Current Symptoms: (*Please check all that apply & leave lines blank.)*

- ☐ Depression _____
- ☐ Sleep Change _____
- ☐ Appetite Change _____ __
- ☐ Crying _____
- ☐ Energy Level_____
- ☐ Weight Change _____
- ☐ Poor Concentration _____
- ☐ Memory Problems _____
- ☐ Pain _____
- ☐ Suicidal Thoughts _____
- ☐ Thought to Harm Others _____
- ☐ Irritability_____
- ☐ Confusion _____
- ☐ Anxiety_____
- ☐ School Problems _____
- ☐ Panic _____
- ☐ Self-injuries _____
- ☐ Racing Thoughts _____
- ☐ Hearing Voices _____
- ☐ Seeing Things _____
- ☐ Odd Beliefs _____
- ☐ Paranoia _____
- ☐ History of abuse _____
- ☐ Nightmares _____
- ☐ Avoiding people/places _____
- ☐ Preoccupations/rituals _____
- ☐ Running Away _____
- ☐ Sexual Problems _____

Please give a brief description of why you're being seen today:

_____

_____

_____

_____

Past psychiatric care *(give dates of treatment if possible)*:

Inpatient: _____

Outpatient: _____

Primary Care Physician: _____

Address: _____

Medical History:

*Illnesses:*_____

_____

_____

Surgeries: _____

_____

_____

Current Medications: _____

_____

_____

Medication Allergies: _____

_____

History of Head Injury: □ Yes □ No

Seizure Disorder: □ Yes □ No

Past psychiatric medications: _____

_____

_____

Suicidal thoughts/plans/attempts: □ Yes □ No

If yes, please explain:

_____

_____

Family History *(Check all that apply.):*

□Depression	□Manic Depressive (Bipolar)	□ Panic attacks
□ Anxiety	□ Eating disorder	□ Sexual/physical abuse
□ Drug use	□ Alcoholism	□ Dementia
□ Schizophrenia	□ Obsessive-Compulsive	□ Mental Retardation

Legal Issues □Yes □No If yes, please explain: _____

_____

_____

Social History:

Occupation: _____

□Married □Single □Divorced □Widowed □Domestic Partner

Highest degree of education: _____

School: _____

GPA: _____ Special classes?: □Yes □No

Persons currently living with you

Number of people in the home: _____

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____

Substance Abuse:

Alcohol use □Yes □No

How much do you drink? _____

Do you need to cut down? □Yes □No

Are you annoyed by comments about your drinking? □Yes □No

Do you feel guilty about things you do when drinking? □Yes □No

Do you need a drink to settle "the shakes?" □Yes □No

Drug use □Yes □No

□Past □Present

□Cocaine □Heroin □Marijuana □Speed □LSD □Others: _____

Tobacco use □Yes □No

□Chew □Snuff □Cigarettes □Pipe □Cigars

Amount per day: _____

Caffeine Use □Yes □No

Amount per day: _____