Date: ___/___/________

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Integrative Psychiatry

Adult Confidential Health Information

Patient's Name:_________________________ Birth Date:______________ Age:________
Sex/Gender identity:
How did you hear about us? ____

Context of Care Review

Successful health care and preventive medicine are only possible when the physician has a complete understanding of the patient physically, mentally, and emotionally. The nature of your response to the following questions will go a long way in assisting my understanding of your truest desires.

What concerns bring you to our clinic? ____
____
Have you been treated for this problem before? ____
Was there any event or action that you or others think that might have contributed to your symptoms (be as detailed as possible)? ____
____
____
Are you currently receiving healthcare? Yes No
If yes, where and from whom? ____
List any accidents, illnesses, injuries, hospitalizations/surgeries or imaging (X-ray, CAT scan, MRI, etc.):
____
____
Are you hypersensitive or allergic to:
Drugs/medications?____
Foods?____
Environmental or chemicals? ____
What long-term expectations do you have from working with our clinic?
____

Current Medications and Supplements

List all medications (from drugstore or prescription) you are taking and dosages:
______________________ ______________________
______________________ ______________________
______________________ ______________________
List all supplements you are taking and dosages:
______________________ ______________________

Current Lifestyle

Highest Education Level:___________________________ Occupational status: ______________________
Relationship status: _______________________________
Name of partner: _________________________________Years together: _______Partner's age: ______
Partner's occupation: ______________________Partner's education level:___________________
Partner's Present Health:____
Total number of children:____________ Prior marriage(s)? Yes No
If yes, date and length of marriage(s):_____________________________
Partner's prior marriage(s) Yes No
If yes, date and length of marriage(s):______________________
What are your top three stressors? Please list and briefly explain:
1. ____
2. ____
3. ____
What are your personal strengths? ____
____
Have you ever had legal issues? Yes/No. If yes, please explain:______________________________
____
____
Have alcohol and/or drugs caused you problems? Yes/No. If yes, please explain:_________________
____
____
Who in your immediate family and extended family has had psychiatric/psychological problems and/or addiction issues? ____
____
List what you eat during a typical day and at what time:
Breakfast: ____
Lunch:____
Dinner:____
Snacks:____
Drinks:____
Do you use caffeine products (soda, coffee, tea, etc.)? Yes No How Much?______________
What foods/drinks do you crave regularly?____
Do you cook for yourself/your family?____

Personal History

Height: _______Weight: _____________ Do you sleep well? _______________________________
Where were you born? ____
Was your birth Normal Premature Long labor Complications
Were you adopted? Yes No If yes, at what age? __________________________________
Father: If living, age and health: ____
If deceased, age, year, and cause of death: ____
Mother: If living, age and health: ____
If deceased, age, year, and cause of death: ____

Adult Mental Health

Have you received previous counseling? Yes No

Psychiatrist Psychologist School Counselor Clergy

If yes, when, why and was it helpful?____

____

____

Have you been admitted to a psychiatric hospital? Yes No.

If yes, when and where?____

____

Have you ever taken psychiatric medications? Yes No. If yes, please list:

Problem Medication Dose Start Date Stopped Date Side Effects Response

1.____

2.____

3.____

4.____

Did you serve in the military? If so, provide details:_______________________________

Spiritual Orientation

Please list your spiritual orientation or religion:__________________________________

How active are these beliefs in your life? Very active Somewhat active Not very active

PLEASE LIST ALL PREVIOUS DIAGNOSES AND CIRCLE OR LIST ISSUES WITH THE FOLLOWING:

1. Health in General: ___No Problems. Lack of energy, unexplained weight gain or loss, loss of appetite, fever, night sweats, grinding teeth at night, other:_________________________

2. Eyes: ___ No Problems. Impaired vision, cataracts, glaucoma, spots in vision, tearing or dryness, eye pain or strain, other:____

____

3. Ears, Nose, Mouth and Throat: ___ No Problems. Difficult with hearing, sinus problems, runny nose, ringing in ears, mouth sores, ear pain, nosebleeds, sore throat, facial pain or numbness, other:____

4. Cardiovascular: ___ No Problems. Irregular heartbeat, racing heart, chest pains, swelling of feet or legs, pain in legs with walking, other:_________________________________

5. Respiratory: ___ No Problems. Shortness of breath, prolonged cough, wheezing, oxygen at home, coughing up blood, asthma, abnormal chest x-ray, other: ______________________

6. Genitourinary: ___ No Problems. Painful urination, frequent urination, urgency, prostate problems, bladder problems, impotence, other: _______________________________

7. Musculoskeletal: ___ No Problems. Joint pain, aching muscles, swelling of joints, joint deformities, other:____

____

8. Gastrointestinal: ___ No Problems. Heartburn, constipation, ulcers, hemorrhoids, diarrhea, abdominal pain, difficulty swallowing, nausea, vomiting, blood in stools, unexplained change in bowel habits, incontinence, other: ____

9. Skin: ___ No Problems. Persistent rash, itching, eczema, acne, hair loss or increase, breast changes, other: ____
____

10. Neurological: ___ No Problems. Brain/head injuries, frequent headaches, double vision, weakness, problems with walking or balance, dizziness, tremor, loss of consciousness, seizures, episodes of visual loss, other:____

11. Psychiatric: ___ No Problems. Insomnia, irritability, depression, anxiety, mood swings, hallucinations, compulsions, other:____
____

12. Female Reproductive: Age of last menses _____, length of cycle _____, duration of menses ____, : last pap smear _____, number of pregnancies ____, number of live births ____

___ No Problems. Irregular cycle, PMS, abnormal PA smear, birth control, pain during intercourse, difficulty conceiving, breast pain/tenderness, menopausal symptoms, other: ________
____
____

13. Male Reproductive: ___ No Problems. Prostate disease, hernias, testicular pain, premature ejaculation, impotence, other:____

14. Hematological: ___ No Problems. Easy bleeding, easy bruising, anemia, abnormal blood tests, leukemia, unexplained swollen areas, other: ____

15. Allergies: ___ No Problems. Seasonal allergies, hay fever symptoms, itching, frequent infections, other: ____

Other

Is there anything else you want me to know or that you think would be helpful or important in your health care? ____
____
____
____
____