UF Health Jacksonville Psychiatry

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Date of Appointment: _____
Age: _____

Today's Date: _____

Adult Patient History Questionnaire

Name:
Preferred Name:
Date of Birth:

Referred By:

What Are Your Concerns That Brought You In Today?

Please Check All Symptoms That You Are Currently Experiencing:

☐ Sad Mood	☐ Racing Thoughts	☐ Panic Attacks	☐ Excessive Dieting
☐ Low Energy/Fatigue	☐ Concentration/Memory Difficulties	☐ Fear of Leaving the House	☐ Focused on Body Weight or Image
☐ Hopelessness	☐ Increased/Decreased Sexual Interest	☐ Fear of Driving	☐ Change in Weight

☐ Guilt	☐ Decreased Appetite	☐ Fear of Specific Situations/Things	History of Trauma/Victim of Abuse ☐
☐ Worthlessness	☐ Increased Appetite	☐ Fear of Being in Public	☐ Offender of Abuse
☐ Crying Spells	☐ Difficulty Falling Asleep	☐ Upsetting Thoughts	☐ Hearing Voices Others Do Not
☐ Decreased Motivation	☐ Excessive Sleeping	☐ Repetitive Thoughts or Behaviors	☐ Seeing Images Others Do Not
☐ Loss of Interest in Usual Activities	☐ Early Morning Waking	☐ Excessively Orderly or Perfectionistic	☐ Bizarre Ideas
☐ Irritability	☐ Suicidal Thoughts	☐ Periods of "Lost" Time	☐ Recent Upsetting Change or Loss
☐ Hyperactivity	☐ Thoughts of Harming Others	☐ Excessive Anger / Aggressiveness	☐ Alcohol Abuse
☐ Impulsiveness	☐ Self Harm/Cutting	☐ Difficulty Trusting Others	☐ Drug Abuse
☐ Elevated Mood	☐ Anxious/Worried	☐ Binge Eating / Purging	☐ Overuse of Prescription Medication

Medications: Please list all medications or supplements that you are **currently** taking.
Include psychiatric and medical medications.

Medication	**Dose** *(mg, units,mL, etc)*	**Doses per day** *(AM, twice daily, at bedtime, etc)*
1.		
2.		
3.		
4.		
5.		
6.		

Have you experienced a head injury? If so, please explain what happened, your age, and if you were unconscious:_____

_____

_____

_____

Primary Care Physician:
Clinic Address and Phone Number:

Current Medical Diagnoses *i.e. asthma, diabetes, seizures, etc*	Treatment?
1.	
2.	
3.	
4.	

Previous Surgeries	Approximate Date	Location/Hospital
1.		
2.		
3.		

Previous Hospitalizations	Approximate Date	Location/Hospital
1.		
2.		
3.		

Medication Allergies:
Food Allergies:

Past Psychiatric History

Have you ever seen a psychiatrist? If so, please provide information about providers, dates, and treatment rendered.

_____

_____

_____

Have you ever seen a psychologist?

_____

_____

_____

Have you ever seen a therapist (*i.e. LMHC, LCSW, LMFT*)?

Have you ever been hospitalized for psychiatric reasons? If so, where and when?

Developmental History:
Any Learning Disabilities (*i.e. reading, dyslexia, writing, math, etc)*?:

Attended Special Education Classes?:

Received Any Developmental Services (*i.e. physical, speech, occupational therapy, etc*)?:

Social History:
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partnered
Lives With (Name, Age, and Relation to Yourself):

Highest Grade Attended:

Occupation and Employment (*specialty, where you work, and how long*):

Military history:

Arrest History or Pending Legal Issues (*i.e. divorce, disability, bankruptcy, etc)*:

Family History: Please indicate if there is a family history of the following conditions and **WHO** is affected with the condition.

Anxiety	Heart disease
Depression	Sudden cardiac death
Bipolar disorder	Cancer
ADHD	Alcoholism
Autism	Drug abuse
Eating Disorders	Thyroid problems
Learning disabilities	Seizures
Other psychiatric conditions?	Other medical conditions?

Substance Abuse History: Please circle all that you have used in the past 2 years:

Alcohol Frequency of use:	Marijuana (weed) Frequency of use:
Cocaine (crack, coke) Frequency of use:	Tobacco Frequency of use:
Opiates (heroin, pain killers, methadone) Frequency of use:	Benzodiazepines (Xanax, Klonipin, Ativan, Valium) Frequency of use:
MDMA (ecstasy) Frequency of use:	LSD (acid, hallucinogens) Frequency of use:
Over the Counter (cough syrup, triple C's) Frequency of use:	Bath Salts, Spice, K2 Frequency of use:
Amphetamines (speed, Adderall, Ritalin) Frequency of use:	Inhalants (dusters, whip its) Frequency of use:

Other: Frequency of use:	Other: Frequency of use:

In the past two years, there have been one or more episodes of memory loss due to substance abuse?

Yes ☐ **or No** ☐

There are personality changes due to the use of substances. **Yes** ☐ **or No** ☐

In the past 5 years, there has been one or more arrest due to substance or alcohol use? **Yes** ☐ **or No** ☐

Someone close to you thinks you may have a serious substance abuse problem. **Yes** ☐ **or No** ☐

There is a history of serious problems with the use of substances. **Yes** ☐ **or No** ☐

There is a history of substance abuse treatment. **Yes** ☐ **or No** ☐

Past Psychiatric Medication

Anti Depressants	**Response (Good, Fair, Poor)**	**Antipsychotic**	**Response (Good, Fair, Poor)**
Amitriptyline (Elavil)		Olanzapine (Zyprexa)	
Bupropion (Wellbutrin)		Perphenazine (Trilafon)	
Citalopram (Celexa)		Pimozide (Orap)	
Clomipramine (Anafranil)		Quetiapine (Seroquel)	
Desipramine (Norpramin)		Risperidone (Risperdal)	
Doxepin (Sinequan)		Asenapine (Saphris)	
Escitalopram (Lexapro)		Thioridazine (Mellaril)	
Fluoxetine (Prozac)		Thiothixene (Navane)	
Fluvoxamine (Luvox)		Trifluperazine (Stelazine)	
Imipramine (Tofranil)			
Mitrazapine (Remeron)		**Mood Stabilizers**	
Nefazodone (Serzone)		Carbamazepine (Tegretol)	
Nortriptyline (Pamelor)		Gabapentin (Neurontin)	
Paroxetine (Paxil)		Lamotrigine (Lamictal)	
Phenelzine (Nardil)		Lithium (Lithobid, etc)	
Dexvenlafaxine (Pristiq)		Topiramate (Topamax)	
Sertraline (Zoloft)		Valproic Acid (Depakote, etc)	
Tranylcypromine (Parnate)			
Trazodone (Desyrel)		**ADHD Medications**	
Venlafaxine (Effexor)		Amphetemine salts (Adderall, etc)	
		Clonidine (Kapvay, Catapres)	
AntiAnxiety		Dexmethylphenidate (Focalin)	

Alprazolam (Xanax)		Guanfacine (Intuniv, Tenex)	
Buspirone (Buspar)		Methylphenidate (Ritalin, Concerta, Daytrana, etc)	
Chlordiazepoxide (Librium)		Strattera (Atomoxetine)	
Clonazepam (Klonopin)		Vyvanse (Lisdexamfetamine)	
Clorazepate (Tranxene)			
Diazepam (Valium)		**Miscellaneous**	
Flurazepam (Dalmane)		Thyroid (Synthroid, Cytomel)	
Hydroxyzine (Vistaril)		Dilantin (Phenytoin)	
Lorazepam (Ativan)		Propranolol (Inderal)	
Oxazepam (Serax)		Naltrexone (Revia)	
Temazepam (Restoril)		Benztropine (Cogentin)	
Triazolam (Halcion)		Trihexyphenidyl (Artane)	
Zolpidem (Ambien)		L-Dopa	
Antipsychotic			
Aripiprazade (Abilify)		**Other Medications**	
Fluphenazine (Prolixin)			
Haloperidol (Haldol)			
Lurasidone (Latuda)			