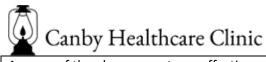


## Personal History Questionnaire: Adult (New Pt)

## General

| Name  |   |  |        |        | DOB   | DOR                |                            | Age                       |  |  |
|---|---|--|--------|--------|---|--------------------|----------------------------|---------------------------|--|--|
| Gender: Gender as if differen   |   |  | _      |        |   | Preferred pronoun: |                            |                           |  |  |
| Telephone (home)  |   |  |        |        |   | (Mobile)           |                            |                           |  |  |
| May I leave a message for you at home?  |   |  |        | ' □Ye  | s □ No  | On mobile p        | On mobile phone? ☐Yes ☐ No |                           |  |  |
| Emergency contact:  |   |  | Relati | onship |   | Phone:             |                            |                           |  |  |
| Mental health/Psychiatric history   |   |  |        |        |   |                    |                            |                           |  |  |
| Please mark any symptoms you believe you experience Currently or in the Past. |   |  |        |        |   |                    |                            |                           |  |  |
| С   | Р |  | C      | Р      |   | С                  | Р                          |                           |  |  |
|   |   | Depressed/sad mood                       |        |        | Muscle tension  |                    |                            | Relationship problems     |  |  |
|   |   | Reduced interest in activities           |        |        | Excessive worry   |                    |                            | Eating problems           |  |  |
|   |   | Appetite/weight change                   | · [    |        | Panic symptoms  |                    |                            | Drug or alcohol problems  |  |  |
|   |   | Frequent crying/tearfulness              |        |        | Boredom   |                    |                            | Gambling problems         |  |  |
|   |   | Low self-esteem                          |        |        | Impulsivity   |                    |                            | Sexual problems           |  |  |
|   |   | Low motivation                           |        |        | Distractibility   |                    |                            | Computer addiction        |  |  |
|   |   | Social isolation                         |        |        | Hyperactivity   |                    |                            | Problems with pornography |  |  |
|   |   | Feelings of hopelessness                 | s      |        | Abnormally elevated mood for several uninterrupted days |                    |                            | Work/school problems      |  |  |
|   |   | Seasonal mood changes                    |        |        |   |                    |                            | Parenting problems        |  |  |
|   |   | Loneliness                               |        |        | Racing thoughts   |                    |                            | Suspiciousness/paranoia   |  |  |
|   |   | Feelings of guilt/shame                  |        |        | Excessive energy  |                    |                            | Hearing or seeing things  |  |  |
|   |   | Sleeping too much or to little           | 0 [    |        | Flashbacks  |                    |                            | Other:                    |  |  |
|   |   | Low energy/fatigue                       |        |        | Nightmares  |                    |                            | Other:                    |  |  |
|   |   | Excessive thoughts of death              |        |        | Easily startled   |                    |                            | Other:                    |  |  |
|   |   | Poor concentration                       |        |        | Anger outbursts   |                    |                            | Other:                    |  |  |
|   |   | Restlessness or feeling of edge/keyed up | on [   |        | Excessive fears   |                    |                            |                           |  |  |
|   |   | Difficulty thinking or making decisions  |        |        | Excessive social dis                                    | scomfort           |                            |                           |  |  |
|   |   | Irritability                             |        |        | Obsessions/compu  | ılsions            |                            |                           |  |  |
|   |   | Frequent anxiety                         |        |        | Fear away from home                                     |                    |                            |                           |  |  |



| Are any of the above symptoms affecting your:  |  |             |  |  |  |  |  |  |
|--|--|-------------|--|--|--|--|--|--|
| $\square$ Ability to engage in your normal daily activities $\square$ work $\square$ school $\square$ housing $\square$ finances $\square$ recreational activities |  |             |  |  |  |  |  |  |
| ☐ legal status ☐ relationships ☐ health ☐ happiness ☐ spirituality ☐ self esteem ☐ sexual activity   |  |             |  |  |  |  |  |  |
|  |  |             |  |  |  |  |  |  |
|  |  |             |  |  |  |  |  |  |
|  |  |             |  |  |  |  |  |  |
| General Health/Medical History   |  |             |  |  |  |  |  |  |
| Primary Care Provider Name:  |  | Last visit: |  |  |  |  |  |  |
|  |  |             |  |  |  |  |  |  |
|  |  |             |  |  |  |  |  |  |
| Medication allergies:  |  |             |  |  |  |  |  |  |
|  |  |             |  |  |  |  |  |  |
| Ongoing medical problems:  |  |             |  |  |  |  |  |  |
|  |  |             |  |  |  |  |  |  |
|  |  |             |  |  |  |  |  |  |
| Past medical problems:   |  |             |  |  |  |  |  |  |
| ,  |  |             |  |  |  |  |  |  |
|  |  |             |  |  |  |  |  |  |
|  |  |             |  |  |  |  |  |  |
| Family medical problems:   |  |             |  |  |  |  |  |  |
|  |  |             |  |  |  |  |  |  |
|  |  |             |  |  |  |  |  |  |
|  |  |             |  |  |  |  |  |  |
| Comment and disable and  |  |             |  |  |  |  |  |  |
| Current medications:   |  |             |  |  |  |  |  |  |
|  |  |             |  |  |  |  |  |  |
|  |  |             |  |  |  |  |  |  |
|  |  |             |  |  |  |  |  |  |

Thank you for taking the time to complete this questionnaire.