Canby Healthcare Clinic

Personal History Questionnaire: Adult (New Pt)

General

Name		DOB	Age
Gender:	Gender assigned at birth if different than current:		Preferred pronoun:
Telephone (home)		(Mobile)	
May I leave a message for you at home? ☐Yes ☐ No		On mobile phone? ☐Yes ☐ No	
Emergency contact:	Relationship		Phone:

Mental health/Psychiatric history

Please mark any symptoms you believe you experience Currently or in the Past.

C	P		C	P		C	P	
☐	☐	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	☐	☐	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 too little	☐	☐	Flashbacks	☐	☐	Other:
☐	☐	Low energy/fatigue	☐	☐	Nightmares	☐	☐	Other:
☐	☐	Excessive thoughts of death	☐	☐	Easily startled	☐	☐	Other:
☐	☐	Poor concentration	☐	☐	Anger outbursts	☐	☐	Other:
☐	☐	Restlessness or feeling on edge/keyed up	☐	☐	Excessive fears			
☐	☐	Difficulty thinking or making decisions	☐	☐	Excessive social discomfort			
☐	☐	Irritability	☐	☐	Obsessions/compulsions			
☐	☐	Frequent anxiety	☐	☐	Fear away from home			

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Are any of the above symptoms affecting your:
☐ Ability to engage in your normal daily activities ☐ work ☐ school ☐ housing ☐ finances ☐ 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:	
Current medications:	

Thank you for taking the time to complete this questionnaire.