## Novant Health Psychiatry and Mental Health Institute Adult Outpatient

**Patient Information**

Patient Name: ______________________ DOB/Age: ______________ Date: ____________

Legal Guardian: ______________________ Documentation Provided: ☐ Yes ☐ No

Referred By: ______________________ Form Completed by: ☐ Self ☐ (Specify) ____________

Primary Care Physician/Assigned Medicaid Provider: ______________________

What brings you here today? (Chief complaint) ______________________

______________________

What are the main stressors in your life right now? ______________________

______________________

______________________

**Please review the list below and check all that apply to you. (If this does not apply, please cross out.)**

**Choose the severity that applies: 1 = mild 2 = moderate 3 = severe**

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Depression | ☐ 1 | ☐ 2 | ☐ 3 | Confusion | ☐ 1 | ☐ 2 | ☐ 3 | Panic Attacks | ☐ 1 | ☐ 2 | ☐ 3 |
| Anxiety | ☐ 1 | ☐ 2 | ☐ 3 | Memory Problems | ☐ 1 | ☐ 2 | ☐ 3 | Obsessive Thoughts | ☐ 1 | ☐ 2 | ☐ 3 |
| Mood Swings | ☐ 1 | ☐ 2 | ☐ 3 | Loss of Interest | ☐ 1 | ☐ 2 | ☐ 3 | Ritualistic Behaviors | ☐ 1 | ☐ 2 | ☐ 3 |
| Irritability | ☐ 1 | ☐ 2 | ☐ 3 | Anger | ☐ 1 | ☐ 2 | ☐ 3 | Hyperactivity | ☐ 1 | ☐ 2 | ☐ 3 |
| Sleep Changes | ☐ 1 | ☐ 2 | ☐ 3 | Excessive Worrying | ☐ 1 | ☐ 2 | ☐ 3 | Aggression | ☐ 1 | ☐ 2 | ☐ 3 |
| Hallucinations | ☐ 1 | ☐ 2 | ☐ 3 | Suicidal Thoughts | ☐ 1 | ☐ 2 | ☐ 3 | Grief | ☐ 1 | ☐ 2 | ☐ 3 |
| Work Problems | ☐ 1 | ☐ 2 | ☐ 3 | Relationship Stress | ☐ 1 | ☐ 2 | ☐ 3 | Poor concentration | ☐ 1 | ☐ 2 | ☐ 3 |
| Racing thoughts | ☐ 1 | ☐ 2 | ☐ 3 | Low Energy | ☐ 1 | ☐ 2 | ☐ 3 | Appetite Changes | ☐ 1 | ☐ 2 | ☐ 3 |
| Insomnia | ☐ 1 | ☐ 2 | ☐ 3 | Self-Injurious Behavior | ☐ 1 | ☐ 2 | ☐ 3 | | | | |
| | | | | Change in Sexual Interest | ☐ 1 | ☐ 2 | ☐ 3 | | | | |

Describe your present symptoms: ______________________

______________________

How long have you had these symptoms? ______________________

______________________

What effect are they having on your life? ______________________

______________________

______________________

**Personal Mental Health History**

Have you ever been treated for a mental health problem? ☐ No ☐ Yes When? ______________________

Where? ______________________ By Whom? ______________________

Have you ever had a mental health hospitalization? ☐ No ☐ Yes When? ______________________

Where? ______________________

Why? ______________________

Current Psychiatrist: ______________________

Current Therapist: ______________________

Have you ever had suicidal thoughts? ☐ No ☐ Yes, please explain: ______________________

______________________

Have you ever attempted suicide? ☐ No ☐ Yes, please explain: ______________________

______________________

______________________

Have you ever been treated with medication for mental health problems? ☐ No ☐ Yes, please list as completely as possible: name of medicines (current and previous), reason prescribed, and response:

______________________

______________________

______________________

**Family Mental Health History**

☐ Single ☐ Married/Partner/Significant Other ☐ Widowed ☐ Separated ☐ Divorced

If ever married, how many times? ______________________

Do you have any children? ☐ No ☐ Yes, how many? ____________ Please list name, age and gender:

______________________

Who lives in your current household? ______________________

______________________

Where were you born? ______________________ Where did you grow up? ______________________

Are you parent's married/separated/divorced? ______________________

Are your parents living? ☐ Yes ☐ No Where do they live? ______________________

How often do you see your parents? ______________________

Do you have siblings (including step and help)? ☐ No ☐ Yes

How do you get along with your family? ______________________

Are you currently having difficulty with any member of your family? ☐ No ☐ Yes, please explain: ____________

______________________

Is family/significant other have any concerns related to treatment? ☐ No ☐ Yes, please explain: ____________

______________________

Have you ever been exposed to any form of abuse? ☐ No ☐ Yes ☐ Verbal ☐ Emotional ☐ Physical ☐ Sexual ☐ Domestic Violence

Was the abuse recent or in the past? Please explain: ______________________

______________________

Have you been exposed to any other trauma (i.e. accident)? ______________________



Patient Name: ______________________

DOB: ____________

Or label

Name / MR # / Label

Have you ever been in the military? ☐ No ☐ Yes When/How long? ______________________________

Have you ever been in combat? ☐ No ☐ Yes When? ______________ Where/How long? ______________________

How did combat affect you? ______________________________________________

Are you a religious person? ______________________________________________

What religion do you participate in? ______________________________________

How might this affect your treatment? ______________________________________

Are there any cultural considerations that might affect your treatment? ______________________

Do you have hobbies? How do you spend leisure/recreation time? ______________________

Are you experiencing any legal problems/involvements that might affect your treatment? ☐ No ☐ Yes

Please explain: ______________________________________________

Are there guns or other weapons in your home? ☐ No ☐ Yes Are they safely secured? ______________

**Work History**

What is your occupation? ______________________________________________

How long have you been with your current employer? ______________________________

Do you enjoy your work?

**Educational Background**

School currently attending/Grade: ______________________________________

Last grade completed: High School/Graduated ______ / ______ College/Degree ______________ / ______________

Post Graduate ______________ / ______________

What is/was your major? ____________________________ Special Interest in School? ______________

Any difficulty in school? ☐ No ☐ Yes, please explain: ______________________________

**Substance Abuse**

Do you drink any alcoholic beverages? ☐ No ☐ Yes/How often/Amount per day: ______________

At what age did you take your first drink? _______ When was your last drink? ________ How much? __________

Have you ever experienced blackouts related to drinking? ☐ No ☐ Yes Details: ______________

Have you ever experienced withdrawal symptoms related to alcohol: Tremors, Excessive Sweating, Nausea/Vomiting, Hallucinations? ☐ No ☐ Yes Details: ______________________

Have you ever used drugs illegally or taken more medication than prescribed? ☐ No ☐ Yes

Details (include names): ______________________________________________

Frequency of drug use: ____________________________ When was the last time? ______________

Have you ever experienced withdrawal symptoms related to alcohol: Tremors, Excessive Sweating, Nausea/Vomiting, Hallucinations? ☐ No ☐ Yes Details: ______________________

If you are not using presently, have you ever used in the past? Details: ______________________

Have you ever received treatment for alcohol or substance abuse problems? ☐ No ☐ Yes, Inpatient

Outpatient Dates of treatment: ______________________ Where? ______________________

Have you ever had any legal charges involving alcohol or substance abuse? ☐ No ☐ Yes

Explain: ______________________________________________

**Medication or Food Allergies** ☐ No ☐ Yes/ List: ______________________________



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**List Daily Medications: Include prescriptions, non-prescription and herbal products**

| Name of Medication | Dosage | Taking as Prescribed? | Last Dose | Prescribed By |
|---|---|---|---|---|
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Patient/Guardian Signature: ______________________ Date: ________ Time: ________

Reviewed by Clinician: ______________________ Date: ________ Time: ________

If limited English proficient or hearing impaired, offer interpreter at no additional cost:

☐ Interpreter Accepted ______________________ ☐ Interpreter Refused

(Name/Number of Person/Services Chosen/Used)



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Or label

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