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.)

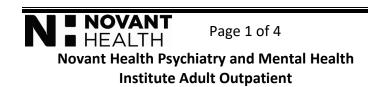
Choose the severity that applies: 1 = mild 2 = moderate 3 = severe

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		2 3	Low Energy	1	2	3	Appetite Changes	1	2	3
Insomnia		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?



Patient Name: _____

DOB:

Or label

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Personal Mental Health History Have you ever been treated for a mental health problem? No Yes When?					
/here? By Whom?					
Have you ever had a mental health hospitalization? 🗌 No 🗌 Yes When?					
Why?					
Current Psychiatrist:					
current inerapist:					
Have you ever had suicidal thoughts? No Yes, please e	explain:				
Have you ever attempted suicide? 🗌 No 🗌 Yes, please expl	ain:				
•	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 If ever married, how many times? Do you have any children? No Yes, how many?					
Where were you born? Where were you born?	here 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					
Was the abuse recent or in the past? Please explain:					
Have you been exposed to any other trauma (i.e. accident)?					
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Have you ever been in the military? No Yes When/H					
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 tro	eatment?				
Do you have hobbies? How do you spend leisure/recreation ti					
	me?				
Are you experiencing any legal problems/involvements that m Please explain:	ight affect your treatment? 🗌 No 🗌 Yes				
Are there guns or other weapons in your home? No	es 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 /					
	ecial Interest in School?				
Substance Abuse					
Do you drink any alcoholic beverages?					
At what age did you take your first drink? When was	·				
Have you ever experienced blackouts related to drinking?	No Yes Details:				
Have you ever experienced withdrawal symptoms related to a Nausea/Vomiting, Hallucinations? No Yes Details:	Icohol: Tremors, Excessive Sweating,				
Have you ever used drugs illegally or taken more medication than prescribed? No Yes					
Details (include names):					
Have you ever experienced withdrawal symptoms related to alcohol: Tremors, Excessive Sweating,					
If you are not using presently, have you ever used in the past?	Detaile				
Have you ever received treatment for alcohol or substance ab					
	here?				
Have you ever had any legal charges involving alcohol or subst Explain:	ance abuse? No Yes				
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

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

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

Name / MR # / Label