

## General Psychiatry

PATIENT'S NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

Accompanied By: \_\_\_\_\_

Relationship: \_\_\_\_\_

### SPECIFIC PRESENT CONCERNS:

<p><b>DEPRESSION:</b></p> <p><i>Do You:</i></p> <p><input type="checkbox"/> Often Get Angry</p> <p><input type="checkbox"/> Sleep too much/difficulty sleeping</p> <p><input type="checkbox"/> Feel hopeless or helpless</p> <p><input type="checkbox"/> Often feel sad/cry</p> <p><input type="checkbox"/> Feel excessively guilty</p> <p><i>Do You Have:</i></p> <p><input type="checkbox"/> Decreased energy or fatigue</p> <p><input type="checkbox"/> Decrease or Increase in appetite</p> <p><input type="checkbox"/> Poor concentration</p> <p><input type="checkbox"/> Loss of interest in activities</p> <p><input type="checkbox"/> Loss of sexual interest</p> <p><input type="checkbox"/> Restlessness or irritability Which interferes with functioning</p> <p><input type="checkbox"/> None of these</p>	<b>Staff Use Only:</b>
<p><b>SUICIDALITY:</b></p> <p>Have you become obviously withdrawn/isolated? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Are you having suicidal thoughts? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Is there a plan? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Is there a means to carry out this plan? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>What has or what could prevent you from acting on plan?</p> <p>Any suicidal thoughts in the past? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, what did you do?</p> <p>Have you ever heard voices telling you to harm yourself? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Have you ever injured yourself on purpose? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Have you had any suicidal attempts or actual suicides by family or friends?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Specify: _____</p>	
<p><b>BEHAVIORS:</b></p> <p>Are you overly aggressive/destructive/argumentative or defiant? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>List any injuries to self or others that resulted from above behavior:</p> <p>Any thought/threats/plans to harm others? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>If yes, describe frequency and intensity of the thoughts: _____</p> <p>Is there any plan/means to carry out plan? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>If yes, who is the individual(s) at risk?</p> <p>Have you made any verbal threats to anyone in the past 2 weeks? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>If yes, describe: _____</p> <p>Have you ever repeated threats to someone? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Do you have any difficulty with hyperactivity/impulsivity or paying attention? <input type="checkbox"/> No <input type="checkbox"/> Yes</p>	
<p><b>COGNITIVE:</b></p> <p><i>Are you experiencing thoughts that:</i></p> <p><input type="checkbox"/> Are racing</p> <p><input type="checkbox"/> Are paranoid/suspicious</p> <p><input type="checkbox"/> Someone is controlling you</p> <p><input type="checkbox"/> Are scattered with inability to focus on one idea</p> <p><i>Are You:</i></p> <p><input type="checkbox"/> Forgetful</p> <p><input type="checkbox"/> Frequently losing things</p> <p><input type="checkbox"/> Seeing/hearing things that aren't real?</p> <p>Explain: _____</p> <p><input type="checkbox"/> None of these</p>	

<p><b>ANXIETY:</b>  <i>Are you:</i></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Fearful, afraid</li> <li><input type="checkbox"/> Nervous/Shaky</li> <li><input type="checkbox"/> Perfectionist</li> <li><input type="checkbox"/> Restless, cannot relax</li> <li><input type="checkbox"/> An uncontrollable worrier</li> <li><input type="checkbox"/> None of these</li> </ul> <ul style="list-style-type: none"> <li><input type="checkbox"/> Withdrawn/avoiding leaving home</li> <li><input type="checkbox"/> Biting your nails/plucking your hair</li> <li><input type="checkbox"/> Thinking repetitive thoughts</li> <li><input type="checkbox"/> Performing repetitive behaviors</li> <li><input type="checkbox"/> Fearful of or are avoiding social situations</li> </ul>	<p><b>Staff Use Only:</b></p>
<p><b>TRAUMA SYMPTOMS:</b>  Have you ever witnessed or experienced a traumatic event (including emotional, physical, or sexual abuse)? <input type="checkbox"/> No  <input type="checkbox"/> Yes  If yes, explain: _____  If yes, have any of the following been experienced/exhibited:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Nightmares</li> <li><input type="checkbox"/> Super alertness to danger</li> <li><input type="checkbox"/> Constant thoughts of trauma</li> <li><input type="checkbox"/> Increase in addictive/compulsive behavior</li> <li><input type="checkbox"/> Overreacting, startle easily</li> <li><input type="checkbox"/> Flashbacks</li> <li><input type="checkbox"/> Avoiding any reminders of event</li> <li><input type="checkbox"/> Sexually abusive behavior towards others</li> <li><input type="checkbox"/> Physically abusive behavior toward others</li> <li><input type="checkbox"/> Difficulty feeling or expressing feelings</li> <li><input type="checkbox"/> Difficulty imagining the future</li> </ul>	
<p><b>EATING HISTORY:</b>  <i>Are You:</i></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> A picky eater</li> <li><input type="checkbox"/> Compulsively overeating</li> <li><input type="checkbox"/> Unduly fearful of becoming fat</li> <li><input type="checkbox"/> Preoccupied with food</li> <li><input type="checkbox"/> Binging on food</li> <li><input type="checkbox"/> Seeing yourself as fat</li> <li><input type="checkbox"/> Preoccupied with appearance</li> <li><input type="checkbox"/> None of these</li> <li><input type="checkbox"/> Compulsively exercising</li> <li><input type="checkbox"/> Fasting to control weight</li> <li><input type="checkbox"/> Vomiting to control weight</li> <li><input type="checkbox"/> Using laxatives to control weight</li> <li><input type="checkbox"/> Having irregular or absent menstrual periods</li> <li><input type="checkbox"/> Having extreme changes in weight</li> <li><input type="checkbox"/> A vegetarian</li> </ul>	
<p><b>SLEEP:</b>  <i>Are You:</i></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Unable to sleep</li> <li><input type="checkbox"/> Having difficulty falling asleep</li> <li><input type="checkbox"/> Time it takes to fall asleep: _____</li> <li><input type="checkbox"/> Experiencing restless sleep/awakening frequently</li> <li><input type="checkbox"/> Taking frequent naps</li> <li><input type="checkbox"/> Snoring or snorting in your sleep</li> <li><input type="checkbox"/> Grinding your teeth while sleeping</li> <li><input type="checkbox"/> Having recurrent nightmares</li> </ul> <p>Duration of problems: _____  Aids used to promote sleep: _____  How many hours of sleep in a 24 hour period: _____  Upon awakening are you:  <input type="checkbox"/> Groggy   <input type="checkbox"/> Rested   <input type="checkbox"/> Other: _____</p>	
<p><b>ADDICTIVE SYMPTOMS:</b>  Have you ever used alcohol or drugs? <input type="checkbox"/> No   <input type="checkbox"/> Yes  If yes, have you ever:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Lost control when intoxicated</li> <li><input type="checkbox"/> Blamed others for use</li> <li><input type="checkbox"/> Sexually acted out</li> <li><input type="checkbox"/> Over used prescription medication</li> <li><input type="checkbox"/> Lost friends due to use</li> <li><input type="checkbox"/> Had job affected</li> <li><input type="checkbox"/> Felt annoyed when people criticized drinking/drug use</li> <li><input type="checkbox"/> Felt guilty about drinking/drug use</li> <li><input type="checkbox"/> Felt that others close to you wished you would cut down on your use</li> <li><input type="checkbox"/> Had a drink upon awakening</li> <li><input type="checkbox"/> Had gambling problems</li> <li><input type="checkbox"/> Stolen from others</li> <li><input type="checkbox"/> Smoked drugs</li> <li><input type="checkbox"/> Sniffed glue/aerosol cans/gasoline/household cleaners</li> <li><input type="checkbox"/> Lost reputation due to use</li> <li><input type="checkbox"/> Felt you should cut down on use of alcohol and/or drugs</li> <li><input type="checkbox"/> Daily</li> <li><input type="checkbox"/> 2-3 times weekly</li> </ul>	

**FAMILY MENTAL HEALTH:**

Have any of your relatives been treated for or taken medicine for mental health or a nervous?

No  Yes

(Check any illnesses that apply and identify the person's relationship to yourself):

M=Mother F=Father S=Sister B=Brother GM=Grandmother GF=Grandfather O=Other

- Depression/ always sad \_\_\_\_\_
- Manic depression/mood swings \_\_\_\_\_
- Anxiety/Nervousness \_\_\_\_\_
- Panic Disorder \_\_\_\_\_
- Suicide \_\_\_\_\_
- Schizophrenia \_\_\_\_\_
- Usually Fearful \_\_\_\_\_
- Substance Abuse \_\_\_\_\_
- Learning Disorder \_\_\_\_\_
- Seeing a therapist \_\_\_\_\_
- Dementia/very confused \_\_\_\_\_
- Sexual Disorders \_\_\_\_\_
- Hearing Voices \_\_\_\_\_
- Alcoholism \_\_\_\_\_
- Anorexia \_\_\_\_\_
- Obsessive/Compulsive \_\_\_\_\_
- Homicide \_\_\_\_\_
- Hyperactive \_\_\_\_\_
- Seeing a psychiatrist \_\_\_\_\_

**Staff Use Only:**

**LEGAL:**

Have you had:

- Any charges or legal offenses (DUI, DWI, PI, felonies/misdemeanors)?  No  Yes

If yes, specify dates \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

- Specify charge(s) and outcome if went to court: \_\_\_\_\_

\_\_\_\_\_

- Violent Offenses?  No  Yes

Explain \_\_\_\_\_

- Current legal charges pending?  No  Yes

If yes, specify charges \_\_\_\_\_

Name of Probation Officer \_\_\_\_\_

- Is treatment a result of your legal problems?  No  Yes

If yes, specify \_\_\_\_\_

- Any lawsuits, divorces, or custody issues in process or being initiated?  No  Yes

If yes, specify \_\_\_\_\_

**PAST TREATMENT HISTORY:**

- Have you had psychiatric/substance abuse treatment in the past?  No  Yes

Inpatient Treatment  Outpatient Treatment  Residential  Day Treatment

- What were you treated for \_\_\_\_\_

Clinic/Facility/Clinician \_\_\_\_\_ Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Clinic/Facility/Clinician \_\_\_\_\_ Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Clinic/Facility/Clinician \_\_\_\_\_ Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Clinic/Facility/Clinician \_\_\_\_\_ Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

- Did you follow up with treatment recommendations?  No  Yes

If no, explain why \_\_\_\_\_

\_\_\_\_\_

- Was treatment helpful?  No  Yes
- Were there any medications prescribed?  No  Yes

If yes, list \_\_\_\_\_

\_\_\_\_\_

- Previous evaluations (psychological, educational, neurological)?  No  Yes

If yes, specify type and date \_\_\_\_\_

\_\_\_\_\_

- Was family therapy included in treatment?  No  Yes
- Was group therapy included in treatment?  No  Yes
- Do you feel you fully participated in treatment?  No  Yes  Partly

## ADULT/SOCIAL DEVELOPMENTAL HISTORY

Patient Name: \_\_\_\_\_ Date \_\_\_\_\_

<p><b>HOUSING:</b>          Are you <input type="checkbox"/> Renting a home/apartment <input type="checkbox"/> Buying/own a home          Are you living with <input type="checkbox"/> Friends <input type="checkbox"/> Relatives          People living with you:          Name/Relationship _____ Names/Relationships _____          _____          _____          Names of Children/Ages: _____ Living with you?          _____ <input type="checkbox"/> No <input type="checkbox"/> Yes          _____ <input type="checkbox"/> No <input type="checkbox"/> Yes          _____ <input type="checkbox"/> No <input type="checkbox"/> Yes          _____ <input type="checkbox"/> No <input type="checkbox"/> Yes          _____ <input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p><b>Staff Use Only:</b></p>
<p><b>FAMILY OF ORIGIN:</b>          • Birth Order _____ Number of Siblings _____          Were your parents: <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Unmarried          If divorced, did your mother remarry or have live-in boyfriend(s)? <input type="checkbox"/> No <input type="checkbox"/> Yes          If yes, specify _____          If divorced, did your father remarry or have live-in girlfriend(s)? <input type="checkbox"/> No <input type="checkbox"/> Yes          If yes, specify _____          Did your family move frequently? <input type="checkbox"/> No <input type="checkbox"/> Yes          Raised by [check the most significant person(s)]:  <input type="checkbox"/> Biological Mother <input type="checkbox"/> Biological Father <input type="checkbox"/> Adoptive Mother  <input type="checkbox"/> Adoptive Father <input type="checkbox"/> Stepmother <input type="checkbox"/> Stepfather  <input type="checkbox"/> Maternal Grandmother <input type="checkbox"/> Maternal Grandfather <input type="checkbox"/> Paternal Grandmother  <input type="checkbox"/> Paternal Grandfather <input type="checkbox"/> Foster Home          If not raised by you biological parents, state why: _____          • How did female caregiver punish you when you did something wrong?  <input type="checkbox"/> Yelled <input type="checkbox"/> Embarrassed <input type="checkbox"/> Shoved <input type="checkbox"/> Threatened <input type="checkbox"/> Spanked  <input type="checkbox"/> Lectured <input type="checkbox"/> Beaten <input type="checkbox"/> Shamed <input type="checkbox"/> Grounded or Restricted Privileges  <input type="checkbox"/> Other: _____          • How did male caregiver punish you when you did something wrong?  <input type="checkbox"/> Yelled <input type="checkbox"/> Embarrassed <input type="checkbox"/> Showed <input type="checkbox"/> Threatened <input type="checkbox"/> Spanked  <input type="checkbox"/> Lectured <input type="checkbox"/> Beaten <input type="checkbox"/> Shamed <input type="checkbox"/> Grounded or Restricted Privileges  <input type="checkbox"/> Other: _____</p>	
<p><b>EDUCATION:</b>          Difficulty with reading/writing? <input type="checkbox"/> No <input type="checkbox"/> Yes Highest Level Completed: _____          Average grades received in high school <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> F          Positive relationship with classmates in school? <input type="checkbox"/> No <input type="checkbox"/> Yes          Positive relationship with authority figures in school? <input type="checkbox"/> No <input type="checkbox"/> Yes          Any drug or alcohol use at the time? <input type="checkbox"/> No <input type="checkbox"/> Yes          If yes, specify what was used, amount, and frequency of use: _____          _____          How do you learn best? <input type="checkbox"/> Hearing Information <input type="checkbox"/> Seeing <input type="checkbox"/> Repetition <input type="checkbox"/> Experience</p>	
<p><b>WORK:</b>  <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired <input type="checkbox"/> On Disability          If employed, what type of work are you doing? _____          Do you enjoy your job? <input type="checkbox"/> No <input type="checkbox"/> Yes Are you currently looking for another job? <input type="checkbox"/> No <input type="checkbox"/> Yes          Does household income pay for the basic necessities? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Barely          If not working currently, what type of work was done in the past: _____</p>	

<p><b>MILITARY:</b>  Current/Previous service in the U.S. Military? <input type="checkbox"/>No <input type="checkbox"/>Yes  If yes, type of discharge: _____  Anything traumatic about the experience in the service? <input type="checkbox"/>No <input type="checkbox"/>Yes  If yes, please explain: _____</p>	<p><b>Staff Use Only:</b></p>
<p><b>MARITAL STATUS:</b>  Are: <input type="checkbox"/>Single <input type="checkbox"/>Married  <input type="checkbox"/>Married, but separated Separated for how long? _____  <input type="checkbox"/>Divorced or Annulled Divorced/Annulled for how long? _____  <input type="checkbox"/>Involved in a committed heterosexual relationship  <input type="checkbox"/>Involved in a committed homosexual relationship  <input type="checkbox"/>If single, divorced, or separated, are you in a new dating relationship? <input type="checkbox"/>No <input type="checkbox"/>Yes  <input type="checkbox"/>If married more than one time, specify the number and length of previous marriage(s): _____    Are you happy in your current relationship? <input type="checkbox"/>No <input type="checkbox"/>Yes  Are there any problems in your current relationship? <input type="checkbox"/>No <input type="checkbox"/>Yes  If yes, please describe: _____</p>	
<p><b>STRESSORS/SUPPORT SYSTEM:</b>  Have you experienced any significant events within the past year such as death of a family member, job loss, relationship problems, etc? <input type="checkbox"/>No <input type="checkbox"/>Yes  If yes, please specify: _____  Have you experienced any significant stressors such as emotional/verbal abuse, physical abuse, neglect, rape, domestic violence, etc? <input type="checkbox"/>No <input type="checkbox"/>Yes  If yes, please specify: _____  List any events beyond one year ago that have had an ongoing negative impact on your life (childhood abuse, losses, divorce, etc.) _____  Who do you rely on for support? _____  What has helped you through difficult times in the past?  _____  Who do you spend your free time with? <input type="checkbox"/>Family <input type="checkbox"/>Friends <input type="checkbox"/>Co-Workers <input type="checkbox"/>Self  Are there any activities you used to do that you would like to do again? <input type="checkbox"/>No <input type="checkbox"/>Yes  If yes, please specify: _____</p>	
<p><b>DEVELOPMENTAL HISTORY:</b>  Did physical maturity occur around the same age as most peers? <input type="checkbox"/>No <input type="checkbox"/>Yes  Age began to date? _____ Did parents object to the individual(s) dated? <input type="checkbox"/>No <input type="checkbox"/>Yes  Sexual Preference? <input type="checkbox"/>Male <input type="checkbox"/>Female <input type="checkbox"/>Both <input type="checkbox"/>Celibate <input type="checkbox"/>Not Sure  Specify: _____ Age of first sexual experience: _____  Any legal problems growing up? <input type="checkbox"/>No <input type="checkbox"/>Yes  Any running away growing up? <input type="checkbox"/>No <input type="checkbox"/>Yes  Any major health problems while growing up? <input type="checkbox"/>No <input type="checkbox"/>Yes  If yes, please specify: _____  Growing up were you <input type="checkbox"/>Very happy <input type="checkbox"/>Happy <input type="checkbox"/>Neither happy/unhappy <input type="checkbox"/>Unhappy</p>	
<p><b>CULTURAL/SPIRITUAL:</b>  Religious preference: _____  Importance of faith during treatment: <input type="checkbox"/>Not at all <input type="checkbox"/>Somewhat <input type="checkbox"/>Significant  Cultural considerations: _____  Medical considerations: _____  Religious restrictions: _____</p>	
<p><b>DISCHARGE:</b>  Is there anything else you would like for us to know?      How will you know that you have met your goals?</p>	

## ADULT GENERAL MEDICAL HISTORY

Patient's Name: \_\_\_\_\_

Date: \_\_\_\_\_

### ALLERGIES/ADVERSE REACTIONS

Substance Drug/Food/Latex/Other	Reaction	Substance Drug/Food/Latex/Other	Reaction

### MEDICATIONS (Prescribed/Over the Counter)

Name	Dose/Schedule	Start Date	Date of Last Dose	Reason	Effective Yes/No	Prescribed By

No medications prescribed or regularly taken

Are there any problems with current medications?  No  Yes

If yes, please specify why?  Financial issues  Scheduling issues  Too Complex  Side Effects  Other: \_\_\_\_\_

<p><b>GENERAL HEALTH:</b>                  Current state of health: <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor                  Date last seen by family MD: _____                  Physical Pain: <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please specify: _____                  Do you receive routine dental care? <input type="checkbox"/> No <input type="checkbox"/> Yes                  Previous Operations/Medical Hospitalizations:                  Type: _____ Date: _____                  Type: _____ Date: _____                  Type: _____ Date: _____                  Childhood Disease:  <input type="checkbox"/> Scarlet Fever <input type="checkbox"/> Rebele <input type="checkbox"/> Polio <input type="checkbox"/> Mumps <input type="checkbox"/> Measles <input type="checkbox"/> Birth Defects <input type="checkbox"/> Rheumatic Fever</p>	<p><b>Staff Use Only:</b>                   Height _____                  Weight _____                  Vital Signs _____                  B/P _____                  Pulse _____                  Respiration _____                  Temp _____</p>
<p><b>EYES/EARS/THROAT:</b>  <i>Have you experienced:</i>  <input type="checkbox"/> Hearing Problems <input type="checkbox"/> Difficulty Swallowing <input type="checkbox"/> Chronic sore throats <input type="checkbox"/> Vision Problems  <input type="checkbox"/> Sinus Problems <input type="checkbox"/> Other: _____  <input type="checkbox"/> None of These                  Corrective Device(s): _____</p>	
<p><b>HEART:</b>  <i>Have you experienced:</i>  <input type="checkbox"/> Chest pain on exertion <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Heart Murmur <input type="checkbox"/> Palpitations <input type="checkbox"/> Low Blood Pressure  <input type="checkbox"/> Other: _____ <input type="checkbox"/> None of These</p>	

<p><b>LUNG:</b>  <i>Do you have:</i>  <input type="checkbox"/> History of Smoking   <input type="checkbox"/> Insufficient energy for routine activities   <input type="checkbox"/> Persistent Cough   <input type="checkbox"/> Asthma  <input type="checkbox"/> Breathing Problems   <input type="checkbox"/> Chronic upper respiratory infection   <input type="checkbox"/> Emphysema   <input type="checkbox"/> Shortness of breath  <input type="checkbox"/> Other: _____   <input type="checkbox"/> None of these</p>	<b>Staff Use Only:</b>
<p><b>NEUROLOGICAL</b>  <i>Have you experienced:</i>  <input type="checkbox"/> Dizziness   <input type="checkbox"/> Tics   <input type="checkbox"/> Seizures   <input type="checkbox"/> Numbness   <input type="checkbox"/> Weakness   <input type="checkbox"/> Headaches/Migraines   <input type="checkbox"/> Falling  <input type="checkbox"/> Involuntary movement   <input type="checkbox"/> Head Injury   <input type="checkbox"/> Tremors   <input type="checkbox"/> Stroke   <input type="checkbox"/> Poor coordination  <input type="checkbox"/> Other: _____   <input type="checkbox"/> None of these</p>	
<p><b>MUSCULOSKELETAL</b>  <i>Do you have:</i>  <input type="checkbox"/> Difficulty walking   <input type="checkbox"/> Fibromyalgia   <input type="checkbox"/> Healing/Skin Problems   <input type="checkbox"/> Back pain   <input type="checkbox"/> Neck pain  <input type="checkbox"/> Arthritis   <input type="checkbox"/> Osteoporosis  <input type="checkbox"/> Other: _____   <input type="checkbox"/> None of these</p>	
<p><b>GASTROINTESTINAL</b>  Current Weight: _____   Height: _____  Recent weight changes?   <input type="checkbox"/> Lost _____ lbs   <input type="checkbox"/> Gained _____ lbs  Over what period of time was weight lost/gained? _____  <i>Have you experienced:</i>   <input type="checkbox"/> Chronic constipation   <input type="checkbox"/> Chronic diarrhea   <input type="checkbox"/> Nausea   <input type="checkbox"/> Vomiting  Aids used to promote regularity, if any: _____  Special dietary needs, if any: _____  How many caffeinated drinks are consumed in a day? _____</p>	Review for Dietary Consult Needs
<p><b>GENITOURINARY</b>  <i>Do you have:</i>   <input type="checkbox"/> Urinary problems   <input type="checkbox"/> Incontinence   <input type="checkbox"/> Urgency/frequency   <input type="checkbox"/> Burning  Are you sexually active?   <input type="checkbox"/> No   <input type="checkbox"/> Yes  <i>Have you experienced:</i>   <input type="checkbox"/> Unprotected sex   <input type="checkbox"/> Infertility   <input type="checkbox"/> Sexual performance problems  Please specify: _____  <b>WOMEN:</b>   <input type="checkbox"/> Pregnant   <input type="checkbox"/> Planned pregnancy   <input type="checkbox"/> Menopausal   <input type="checkbox"/> Difficulty with menstruation, (i.e. PMS)  Please specify: _____  Date of last Pap Smear: _____   Date of last period: _____  <b>MEN:</b> Prostate Disease?   <input type="checkbox"/> No   <input type="checkbox"/> Yes</p>	
<p><b>ENDOCRINE:</b>  <i>Do you have a history of:</i>  <input type="checkbox"/> Diabetes   <input type="checkbox"/> Hypoglycemia   <input type="checkbox"/> Hyperthyroid   <input type="checkbox"/> Hypothyroid  <input type="checkbox"/> Other _____   <input type="checkbox"/> None of these</p>	
<p><b>EXPOSURES/INFECTIOUS DISEASES:</b>  <i>Have you had any exposure to:</i>  <input type="checkbox"/> Pesticides   <input type="checkbox"/> Lead Pipes   <input type="checkbox"/> Carbon Monoxide   <input type="checkbox"/> Lead Paint   <input type="checkbox"/> Poison  Check any of the following communicable diseases/infections that you have had exposure to in the past month:  <input type="checkbox"/> Measles   <input type="checkbox"/> Cold   <input type="checkbox"/> Flu   <input type="checkbox"/> Chicken pox   <input type="checkbox"/> TB   <input type="checkbox"/> Sexually Transmitted Diseases  How recent was your exposure: _____  <i>Do you have a history of:</i>  <input type="checkbox"/> Hepatitis   <input type="checkbox"/> Tuberculosis   <input type="checkbox"/> AIDS   <input type="checkbox"/> Meningitis   <input type="checkbox"/> Blood Transfusions   <input type="checkbox"/> IV Drug Use  <input type="checkbox"/> Sharing Needles   <input type="checkbox"/> Sexually Transmitted Diseases  <input type="checkbox"/> Previous reaction to TB Skin Test _____   Date of last skin test _____  If under 21 years of age, are immunizations up to date?   <input type="checkbox"/> No   <input type="checkbox"/> Yes   <input type="checkbox"/> Unsure  <input type="checkbox"/> None of these</p>	

**EXERCISE/SELF CARE ACTIVITIES:**

Do you:  Regularly exercise  Have a sedentary lifestyle

Do you need help with:

	<u>Needs Assistance</u>	<u>Needs Total Care</u>	<u>Assistive Devices</u>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Cane
Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Wheelchair
Hygiene	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Walker
Feeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Splints
Toileting	<input type="checkbox"/>	<input type="checkbox"/>	
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	

**Staff Use Only:**

Signature of Patient/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_