Advanced Psychiatry of Elgin

Child, Adolescent and Adult Psychiatry

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PHYSICAL HEALTH ASSESSMENT SOCIAL HISTORY

Client ID:
Patient:

Instruction: If you are filling this out on behalf of the patient, please answer from the patient's perspective.

Stressors

	None	Mild stress	Moderate stress	Severe stress
Family				
Friends				
Relationships				
Educational				
Economic				
Occupational				
Housing				
Legal				
Health				

Substance Abuse History

Do you have a history of any recreational drug use? Yes _____ No_____

If YES, please fill out the table below to the best of your knowledge:

Substance(s) used:	Yes	No	Age of first use	Age of last use	How was it taken	Amount per day	Days per month
Amphetamines/Speed							
Barbiturates/Downers							
Opiates							
Cocaine							
Psychedelics (e.g., LSD, Ecstasy, bath salts)							
Inhalants (e.g., glue, aerosols)							
Cannabis/Marijuana/ Hashish							
Benzodiazepines							
PCP							

Substance Abuse Treatment History

Did you receive any treatment for substance abuse? Yes_____ No_____
If YES, please fill out the table below to the best of your knowledge:

Treatment type	Yes	No	How many episodes of treatment	Age of first treatment	Age of last treatment	Any additional treatment information
Inpatient						
Intensive Outpatient						
Outpatient						
12-Step						
Program						

Consequences of Substance Abuse

Have you experienced any of these consequences as a result of alcohol consumption or abuse of substances? (Please check all that apply)

_____ No consequences
_____ Felt that you needed to cut down on your drinking
_____ Been annoyed by others criticizing your drinking
_____ Felt guilty about drinking
_____ Needing a drink first thing in the morning
_____ Increased tolerance
_____ Withdrawal (shakes, sweating, nausea, rapid heart rate)
_____ Seizures
_____ Blackouts
_____ Effects on physical health
_____ Using/consuming more than intended
_____ Unintentional overdose
_____ DUI
_____ Arrests
_____ Physical fights or assaults
_____ Relationship conflicts
_____ Problems with money
_____ Job loss or problems at work/school
Other: _____

Inpatient Psychiatric History

Do you have a history of inpatient psychiatric treatment? Yes_____ No_____

Please list any past inpatient treatment history below. Start with most recent and list each episode of treatment as a separate line.

Hospital/Facility	Treatment voluntary	Primary reasons for hospitalization	How old were you	Treatment outcome	Additional comments

Outpatient Psychiatric History

Do you have a history of outpatient psychiatric treatment? Yes_____ No_____

Please list any past outpatient treatment history below. Start with most recent and list each episode of treatment as a separate line.

Provider	Primary reason for seeking treatment	Age of first treatment	Age of last treatment	Outcome	Additional comments

Suicide/Self-Harm History

Have you ever tried to harm or kill yourself? Yes____ No____
If you answered "no", skip the rest of the questions

Was your intent to die? Yes____ No____
Elaborate, if desired:_____
How many times in your life has this occurred?_____

Most Severe Episode

Please describe your most severe episode including date, method, and consequences:

Date:	
Method:	
Consequences:	

Date:	
Method:	
Consequences:	

Violence History Assessment

Have you had any history of violent behavior? Yes_____ No_____

Past Medical History

Who is your primary care physician?_____

Are you taking any medications currently? (Excluding medications for psychiatric treatment) Yes___ No____
If yes, please include these medications below:

_____

_____

_____

_____

_____

_____

Have you had a history of any of the following health problems? (Please check all that apply)

No Problems	Diverticulitis	Hermorrhoids	Lupus
Allergies	Fainting spells/	Hepatitis	Migraine Headaches
Anemia	Passing Out	Hernia	Multiple Sclerosis
Arthritis	High Cholesterol	HIV	Obesity/Overweight
Asthma	Fibromyalgia	Hypertension (High	Parkinson's Disease
Back problems	Gall Bladder Disease	blood pressure)	Polyps
(including disk or spine)	Gastritis or Ulcer	Hypotension (Low	Sexually Transmitted
Cancer	Glaucoma	blood pressure)	Disease (STD)
Cataracts	Gout	Inflammatory Bowel	Sleep Apnea
Chickenpox (as a child)	Hearing Loss	Iron Deficiency	Stroke/TIA
Chronic Bronchitis	Heart Disease	Kidney Disease	Testosterone (low)
COPD (Emphysema)	Heart defect from birth	Kidney Stones	Thyroid problems
Diabetes	Heart valve problems	Liver Disease (other)	(hypothyroid/hyperthyroid)
Other:			Tuberculosis

Have you had a history of surgery in any of the following areas? (Please check all that apply)

No Surgical History	Hernia	Kidney	Sex Change
Back/Neck	Hip/Knee/Ankle/Foot	Liver	Shoulder/Elbow/
Brain	Hysterectomy	Lung	Wrist/Hand
Cardiac	(Ovaries Removed)	Pancreas	Stomach
Ear/Nose/Throat	Hysterectomy	Pelvis	Tonsils
Gall Bladder	(Ovaries Retained)	Penis	Vagina
Other:	Intestine	Prostate	Weight Loss

Psychiatric Medication History

Have you ever taken any medication for psychiatric treatment? Yes_____ No_____

If YES, please fill out the table below to the best of your knowledge:

Medication name	Dose	How long (months)	End date	Therapeutic effect	Side effects	Reason for stopping

Patient Allergies

Do you have any known allergies to medication? Yes_____ No_____

If YES, please fill out your allergy information below:

Medication allergy	Allergic reaction

Family Psychiatric History

Do you have any family members with a history of psychiatric illness? Yes_____ No_____

If YES, please elaborate below:

Family member	Psychiatric problem(s)

Family Medical History

During your pregnancy/birth, did your mother have any problems with any of the following:

_____ None of these
_____ Exposure to drugs or alcohol during pregnancy
_____ A difficult pregnancy
_____ Problems with delivery
Other: _____

Did you have any complications after your birth? (e.g. premature birth, jaundice, breathing difficulties)
Yes_____ No_____

Did you have any delays or difficulties in reaching the following developmental milestones?

_____ None of these
_____ Walking
_____ Talking
_____ Toilet training
_____ Sleeping alone
_____ Being away from parents
_____ Making friends
Other: _____

Which options below best describe your childhood home atmosphere?

_____ Normal
_____ Supportive
_____ Parental fighting
_____ Parental violence
_____ Financial difficulties
_____ Frequent moving
Other: _____

Which of the following challenges were experienced during your childhood?
_____ None of these
_____ Tantrums
_____ Enuresis (bed wetting)
_____ Encopresis (fecal incontinence)
_____ Running away from home
_____ Fighting
_____ Stealing
_____ Property damage
_____ Fire setting
_____ Animal cruelty
_____ Separation anxiety
_____ Victim of bullying
_____ Engaged in bullying
_____ Depression
_____ Death of a parent/caregiver
_____ Parental divorce

Which of the following best describe problems you may have had in school?
_____ None of these
_____ Fighting
_____ Social phobia
_____ Truancy
_____ Detentions
_____ Suspensions
_____ Expulsions
_____ School refusal
_____ Class failures
_____ Repetition of grades
_____ Special education
_____ Remedial classes

Did you have additional schooling outside of the standard classroom setting? (Please check all that apply)
_____ None of these
_____ Speech classes
_____ Tutoring
_____ Accommodations
Other: _____

What is your highest level of education? _____

General Social History

Which options below best describes your social situation?
_____ Supportive social network
_____ Few friends
_____ Substance-use based friends
_____ No friends
_____ Distant from family of origin
_____ Family conflict
Other: _____

What is your marital status:_____

Who do you currently live with? (Please check all that apply)
_____ Live alone
_____ Roommates
_____ Partner/Spouse
_____ Parent(s)
_____ Sibling(s)
_____ Children
Other: _____

What is your current occupation status:_____

Menstruation and Pregnancy History

At what age did you begin menstruation?_____

Which of these best describe your premenstrual symptoms?
_____ None of these
_____ Dysphoria
_____ Cramps
_____ Appetite change
_____ Bloating
_____ Sleep disturbance

Do you have a method of contraception? (Please check all that apply)
_____ No method of contraception
_____ Intrauterine (e.g., IUD)
_____ Hormonal (e.g., implant, injection, "the pill", patch, hormonal vaginal contraceptive ring)
_____ Barrier (e.g., diaphragm, male/female condom, spermicide)
_____ Fertility Awareness-based (e.g., natural family planning)
_____ Permanent (e.g., male/female sterilization, infertility)
Other: _____

Review of Systems

Please look at the list of physical symptoms below and check off any that you have experienced in the last several days. If you have NOT experienced any symptoms in an area, be sure to check "None of the above" for that area.

Constitutional	**Eyes**	**Ears, Nose, Mouth, and Throat**
Chronic pain	Eye pain	Earache
Loss of appetite	Eye discharge	Tinnitus (ringing in ears)
Increase in appetite	Eye redness	Decreased hearing or hearing loss
Unexplained weight loss	Blurred or double vision	Frequent ear infections
Weight gain	Visual change	Frequent nose bleeds
Fatigue/Lethargy	History of eye surgery	Sinus congestion
Unexplained fever	Sensitivity to light	Runny nose/Post-nasal drip
Hot or cold spells	Scotomas (Blind spots)	Difficulty swallowing
Night sweats	Retinal hemorrhage	Frequent sore throat
Sleeping pattern	(Floaters in vision)	Prolonged hoarseness
disruption	Amaurosis fugax	Pain in jaw or tooth
Malaise (Flu-like or	(Feelinglike a curtain is	Dry mouth
vague sick feeling)	pulled over vision)	
Other:	Other:	Other:
None of the above	None of the above	None of the above

Cardiovascular	**Respiratory**	**Musculoskeletal**
Chest pain	Pain with breathing	Swelling in joints
Pacemaker	Chronic cough	Redness of joints
Palpitations (fast or irregular heartbeat	Chronic shortness of breath	Other joint pains or stiffness
		Frequent ear infections
Swollen feet or hands	Chronic wheezing/Asthma	Muscle pain or cramping
Fainting spells	Excessive phlegm	Muscle weakness
Shortness of breath	Coughing blood	Muscle stiffness
	Nocturnal Dyspnea (Shortness of breath at night	Decreased range of motion
		Back pain or stiffness
		History of fractures
		Past injury to spine or joints
Other:	Other:	Other:
None of the above	None of the above	None of the above

Gastrointestinal		
Excessive flatulence or belching	Heartburn	Change in appearance of stool
	Difficulty swallowing solids or liquids	Blood in stool Dark/Tarry stool
Diarrhea		
Constipation	Recent loss in appetite	Loss of bowel control/soiling
Persistent nausea/vomiting	Sensitivity to milk products	
Abdominal pain	Jaundice (yellow skin)	
Other:		
None of the above		

Allergic/Immunologic	**Endocrine**	**Hematologic/Lymphatic**
Frequent infections	Severe menopausal symptoms	Blood clots
Hives	Cold or heat intolerance	Excess/easy bleeding (surgery, dental work, brushing teeth, scrapes)
Anaphylaxic reaction	Excessive appetite	
	Excessive thirst or urination	History of blood transfusion
	Excessive sweating	Excessive bruising
		Swollen glands (neck, armpits, groin)
Other:	Other:	Other:
None of the above	None of the above	None of the above

Genitourinary (General)	Genitourinary (Women)	Genitourinary (Men)
Loss of urine control (include bed-wetting)	Unusual vaginal discharge	Slow urine stream
Painful/Burning urination	Vaginal pain, bleeding, soreness, or dryness	Scrotal pain
Blood in urine	Genital sore	Lump or mass in the testicles
Increased frequency of urination	Heavy or irregular periods	Abnormal penis discharge
Up more than twice/night to urinate	No menses (Periods stopped)	Trouble getting/maintaining erections
Urine retention	Currently pregnant	Inability to ejaculate/orgasm
Frequent urine infections	Sterility/Infertility	Any other sexual or sex organ concerns
Other:	Any other sexual or sex organ concerns	
None of the above	Other:	Other:
	None of the above	None of the above

Neurological	Integumentary Skin/Breast and Hair)	Psychiatric
Paralysis	Lesions	In-depth review of psychiatric systems appears earlier in document (to be checked by clinician only)
Fainting spells or blackouts	Unusual mole	
Dizziness/Vertigo	Easy bruising	
Drowsiness	Increased perspiration	Feeling depressed
Slurred speech	Rashes	Difficulty concentrating
Speech problems (other)	Chronic dry skin	Phobias/Unexplained fears
Short term memory trouble	Itchy skin or scalp	No pleasure from life anymore
Memory difficulties (loss)	Hair or nail changes	Anxiety
Frequent headaches	Hair loss	Insomnia
Muscle weakness	Breast tenderness	Excessive moodiness
Numbness/Tingling sensations	Breast discharge	Stress
Neuropathy (numbness in feet)	Breast lump or mass	Disturbing Thoughts
Tremor in hands/shaking		Manic episodes
Muscle spasms or tremors		Confusion
Other:		Memory loss
None of the above	Other:	Nightmares
	None of the above	Other:
		None of the above