SELF-ASSESSMENT FORM

Please Print

Name:			Date:
Street:			Suite/Apt. #:
City:	State:	Zip Code:	County
Mark an 'X' in the preferred method of contact			
Phone (home): ☐	Phone (cell): ☐	Phone (work): ☐	
Age:	Patient's Date Of Birth (Month/Day/Year):		
Patient's SS#:			
Email Address:			

•

Name of Person with whom you live:	Relationship:	
Name of person to call in an emergency:	Relationship:	
Street:		Suite/Apt. #:
City:	State:	Zip Code:
Phone (home):	Phone (cell):	
Name of person filling out this form (if not patient):		
Relationship to patient:		

For Office Use Only

• New Patient • New Case • Hours • ICANotes • Pharmacy • PaperVision

Chart ID: _____

REFERRAL INFORMATION		
Name of referring patient or responsible physician/clinician:		
Street: Suite/Apt. #:		
City:	State:	Zip Code:
Phone (work):		

Check those that apply.

RACE
•**American Indian or Alaska Native** – Print origin(s), for example, Navajo, Blackfeet, Inupiat, Yup'ik, or Central American Indian groups or South American Indian groups, etc.
•**Asian** – Print origin(s), for example, Chinese, Filipino, Asian Indian, Vietnamese, Korean, Japanese, etc.
•**Black or African American** – Print origin(s), for example, African American, Jamaican, Haitian, Nigerian, Ethiopian, Ghanaian, etc.
•**Native Hawaiian or Other Pacific Islander** – Print origin(s), for example, Native Hawaiian, Samoan, Guamanian or Chamorro, Tongan, Fijian, Marshallese, Palauan, Pohnpeian, Chuukese, Yapese, etc.
•**White** – Print origin(s), for example, German, Irish, English, Italian, Lebanese, Egyptian, etc.
•**Arab-American**
,QGLDQ 3DNLVWDQL
+LVSDQLF /DWLQR
6RPH RWKHU UDFH RU RULJLQ

RELIGION	
•Evangelical Protestant	•Baptist
•Protestant	•Jewish
•Catholic	•Muslim
•Orthodox Christian	•Buddhist
•Greek Orthodox	•Hindu
•Russian Orthodox	•Atheist
•Mormon	•Agnostic
•Jehovah's Witness	•Don't Know
•Other Christian	•Decline to Answer

RESIDENCE			
•House	•Apartment	•Rented Room	•Dormitory
•Condo	•Townhouse	•Hospital (Print Name):	
•Co-op Living	•Hotel	•Other	
Nursing Home (Print Name):			

Gender	Marital Status	
•Female •Male •Transgender	•Never Married •Married •Living Cooperatively	•Divorced •Process of Divorcing •Legally Separated/Separated
	If married, how many times? 1 2 3 Other_____	If divorced, how many times? 1 2 3 Other_____
	•Marriage annulled	•Widow/widower •Other _____

Occupation	Student
	F/T or P/T circle one

Education (please specify highest level completed)		
High school and earlier (circle one) 6th or earlier 7th 8th 9th 10th 11th 12th	College/university (circle one) 1 2 3 4 5 Other_____ Student	Graduate school (circle one) BA BS MA MS MBA PHD Other_____ MD JD
•Technical School	•Trade School	•Certificate Program
•GED		

Please state the principal reason you are requesting a consultation or treatment.

If necessary, use another sheet of paper.

Please describe your illness from the time of your first symptom to the present. Provide as many dates, names, and addresses of psychiatrists, psychologists, and/or social workers who have treated you as you can. Also, please provide the kinds of treatment you have received, including names of medications and your response to them.

,f necessary, use another sheet of paper.

Medical History

Weight and Height

What is your current weight in pounds? _____ lbs.
☐ Check if your weight has increased or decreased by more than 10 pounds during the last 5 years
If checked, explain circumstances.
What is your height in inches? _____ in.

Sleep

Check if you -
☐ have difficulty falling asleep
☐ have difficulty waking up and falling back to sleep
☐ are tired on waking
☐ have bad dreams, wet bed, sleepwalk or other sleep disturbances

Smoking

☐ Check if you smoke.
If checked, how much and for how long?

Caffeine

☐ Check if you drink coffee, tea or colas.
If checked, how much?
☐ Check if you believe you are sensitive to caffeine.

Allergies

List all allergies. Be sure to include medication allergies.

Medical Problems

Age when first occurred	List all past and present medical problems as well as any surgery or accidents.

Females – Menstrual History

☐ Check if your periods are irregular.
If checked, explain.

What is the duration of your periods?

What is the date of your last period?

☐ Check if your periods are irregular.
If checked, explain. Check if there is any pain or discomfort with your periods.

☐ Check if your moods, depression, irritability, or irrationality change with your periods?
If checked, how?

☐ Check if you are taking an oral contraceptive.
If checked, which one and for how long?

☐ If taking an oral contraceptive, check if it affects your mood.

Suicide	Drinking (Alcohol Use)
•Check if you have ever thought about suicide. If "yes," when was the last time? •Check if you have ever attempted suicide. If "yes," when and how? • Check if you have thoughts about suicide now.	How many drinks do you consume in the average day? At what time of day do you have your first drink? What is the most you have had to drink in a 24-hour period during the last year? •Check if you ever felt that you were, or someone told you that you were, drinking too much? If "yes," under what circumstances?
Injury to Others	**Drugs of Abuse** **Check if you have taken any of the following drugs.**
•Check if you have ever thought about hurting someone else. If "yes," when was the last time? •Check if you have ever hurt someone else. If "yes," when and how? • Check if you are thinking about hurting someone now.	• None •Marijuana •Amphetamines/speed •Heroin/opiates •PCP •LSD/hallucinogens •Cocaine/crack •Barbiturates/sedatives/downers If you checked one or more of the drugs, under what circumstances did you take it (them)? When did you most heavily use drugs? When was the last time you took such drugs?
Recent Stressful Life Events **Check any of the following events that have occurred during the last 2 years.**	**Personal History** **Check any items that apply to you and explain.**
•Married •Engaged •Separated •Divorced •Serious argument •Breakup of important relation •Child left home •Death of spouse, other •Bad health (behavior) of family member •Difficulties with family member •Personal injury, illness •Sexual difficulties •Difficulties, changes at school, work •Retired, lost job •Changed residence •Legal difficulties, multiple traffic tickets •Owe money	•Mother's pregnancy with you was normal •Mother's delivery of you was abnormal Check if during childhood you - ••were afraid to go to school ••had difficulty w/ reading, writing or arithmetic/math ••were truant ••failed or repeated a grade ••bad frequent falls ••were awkward at games ••wet bed after age 5 ••had tics ••had trouble with eyes ••were (are) left handed ••mispronounced words, had a lisp, stutter/stammer ••had nightmares, disturbed sleep, fear of the dark ••ran away from home ••were cruel to animals ••often lied to families or others ••set fires ••moved often ••were exposed to incest ••were promiscuous

Family History				Major Illnesses	
Name		Age[a]	Occupation[b]	List all major illnesses, including psychiatric, neurological, alcoholism, drug abuse, suicide, and suicide attempts.	
Mother					
Father					
Brothers					
Sisters					
Children					
Grandparents, uncles, and aunts (relationship)					

[a]Or if deceased, age at death.

[b]Or if deceased, cause of death