

Patient Label



PMG Psychiatry Clinic West
9155 SW Barnes Rd
Suite 333
(503) 216-5102 (Phone)
(971) 712-2179 (Fax)

Name _____ Date of Birth _____ Date _____

Preferred pronoun? [] She/Her/Hers [] He/Him/His [] They/Them/Theirs [] Other _____

What problem(s) are you seeking help for? _____

I am interested in [] psychiatric medication [] therapy [] both
[] I already have a therapist Name of current Therapist _____ Phone _____

What are your biggest stressors? _____

What are your treatment goals? _____

Table with 2 columns of symptoms and 5 columns of rating (0-4). Symptoms include: Feeling restless, agitated; Dramatic mood swings; Reckless, impulsive behaviors; Really high energy/no need for sleep; Irrational fears or thoughts; Thoughts that frighten you; Seeing things others do not see; Feeling you could hurt someone; Hearing voices others do not hear; Feeling someone is watching you; Feel that people plot against you; Others can read your thoughts; Feeling anxious and worried; Afraid to leave home; Spells of terror or panic; Heart pounding or racing; Checking, rechecking things; Feeling the need to count things; Gambling; Feeling empty; Intense emotional reactions; Urges to injure yourself; Nightmares; Always "on alert" or "on guard"; Easily startled; "Flashbacks" of past trauma; Sense of "unreality"; Trouble with painful memories; Never feeling close or connected; Vomiting; Feel ashamed of my body; Binge eating; Restricted eating; Purging via laxatives or excessive exercise; Feeling others are unsympathetic; Fear of being abandoned by others; Pattern of relationship problems; Feeling easily irritated and annoyed.

Patient Label



PMG Psychiatry Clinic East
5225 NE Hoyt Street, Bldg. B
Suite 300
(503) 215-4860 (Phone)
(971) 282-0138 (Fax)

Past Psychiatric History: Have you had therapy or psychiatric care in the past? Yes No If yes, please describe:

By Whom _____ Reason _____ Dates treated _____ Where _____

Have you been to the emergency department or been hospitalized for psychiatric reasons? Yes No

If yes, please describe further:

By Whom _____ Reason _____ Dates treated _____ Where _____

Risk Assessment

Have you ever had feelings or thoughts that you didn't want to live? Yes No

Do you currently feel like you don't want to live? Yes No

Have you ever tried to kill yourself before? Yes No

If Yes, how and when? _____

Do you have access to firearms or other weapons? Yes No

If yes, what? _____

Have you ever assaulted anyone before? Yes No

Any current or previous self-harm (cutting, burning, bruising, etc.)? Yes No

If current, what method and how often? _____

Substance Use History

Do you use:	No	Yes	How much?	How often?	Date last used?	Has use ever been excessive/problematic?	Have you ever had treatment?
Alcohol							
Tobacco							
Marijuana							
Cocaine							
Methamphetamines							
Heroin/Opiates							
Others:							

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Relational History Are you currently: Single Married Partnered Divorced Widowed
 In a relationship? How long? _____ Occupation of significant Other? _____
How would you describe your relationship? _____
Prior marriages? Yes No If yes, how many for how long? _____
Do you have children? Yes No If yes, age(s) and gender(s)? _____
How would you describe your relationship with your children? _____
What is your current living situation? _____

What other community resources have you accessed that support your mental health? (e.g. church, family, friends, therapist, volunteering, etc.)

Trauma History Have you survived or been a witness to traumatic events (such as war, medical traumas, natural disasters, bullying, car accidents, or emotional, physical, sexual, verbal abuse, or neglect) ? Yes No
If yes, please explain: _____

Occupational History Highest level of education or degree obtained: _____
Are you currently? Working Not working by choice Unemployed Disabled Retired
Occupation: _____ Where do you work? _____

Have you ever been in the military? Yes No If yes, what branch and when? _____

Legal Have you ever been arrested? Yes No If yes, for? _____
Any charges other than for minor traffic violations? Yes No If yes, for? _____
Any current pending legal problems? Yes No If yes, please explain? _____

I identify my ethnicity as: (please select all that apply)

- | | |
|--|---|
| <input type="checkbox"/> African American/Black | <input type="checkbox"/> Native Hawaiian/Pacific Islander |
| <input type="checkbox"/> Alaska Native/Native American | <input type="checkbox"/> Middle Eastern |
| <input type="checkbox"/> Asian or Asian Indian | <input type="checkbox"/> White |
| <input type="checkbox"/> Hispanic/Latino | <input type="checkbox"/> Prefer not to say |
| | <input type="checkbox"/> Other: _____ |

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Gender: Check as many as are appropriate

- Female Male Transgender (*Female to Male* *Male to Female* *Other*) non-binary/non-conforming
 Other _____

Sexual Orientation Identity

- Bisexual Lesbian
 Gay Queer
 Heterosexual/Straight Not Sure
 Other (please feel free to explain) _____

What do you do for recreation/do you have any hobbies? _____

Do you have any other personal goals? _____

What are some of your strengths? _____

What are some of your challenges? _____

Personal and Family Psychiatric History Checklist

	You	Family	Which Family Member(s)
Depression			
Anxiety			
Obsessive Compulsive Disorder			
Post-traumatic stress			
Bipolar Disorder			
Schizophrenia			
Anger / Violence			
Attention Deficit			
Alcohol Abuse			
Substance/Drug Abuse			
Dementia			
Suicide			
Personality Disorder			
Other			