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Health & Services

Psychiatry
Milwaukie

Name _____ Date of Birth _____ Date _____

Name of person completing packet if different from above _____

Relationship to patient _____

What do you want us to know regarding race/ethnicity, gender identity/preferred pronouns, sexual orientation, and religious affiliation? _____

Name of current Therapist _____ Phone _____

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

_____

What are your treatment goals? _____

_____

Have you recently experienced any of these symptoms?

0 = not at all 1= a little 2 = some 3 = quite a bit 4 = extremely

Feeling restless, agitated	0	1	2	3	4	Feeling empty	0	1	2	3	4
Dramatic mood swings	0	1	2	3	4	Intense emotional reactions	0	1	2	3	4
Reckless, impulsive behaviors	0	1	2	3	4	Urges to injure yourself	0	1	2	3	4
Really high energy/no need for sleep	0	1	2	3	4	Nightmares	0	1	2	3	4
Irrational fears or thoughts	0	1	2	3	4	Always “on alert” or “on guard”	0	1	2	3	4
Thoughts that frighten you	0	1	2	3	4	Easily startled	0	1	2	3	4
Seeing things others do not see	0	1	2	3	4	“Flashbacks” of past trauma	0	1	2	3	4
Feeling you could hurt someone	0	1	2	3	4	Sense of “unreality”	0	1	2	3	4
Hearing voices others do not hear	0	1	2	3	4	Trouble with painful memories	0	1	2	3	4
Feeling someone is watching you	0	1	2	3	4	Never feeling close or connected	0	1	2	3	4
Feel that people plot against you	0	1	2	3	4	Vomiting	0	1	2	3	4
Others can read your thoughts	0	1	2	3	4	Feel ashamed of my body	0	1	2	3	4
Feeling anxious and worried	0	1	2	3	4	Binge eating	0	1	2	3	4
Afraid to leave home	0	1	2	3	4	Feeling others are unsympathetic	0	1	2	3	4
Spells of terror or panic	0	1	2	3	4	Fear of being abandoned by others	0	1	2	3	4
Heart pounding or racing	0	1	2	3	4	Pattern of relationship problems	0	1	2	3	4
Checking, rechecking things	0	1	2	3	4	Gambling or excessive spending	0	1	2	3	4
Feeling the need to count things	0	1	2	3	4	Feeling easily irritated and annoyed	0	1	2	3	4

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Suicide Risk Assessment

Have you ever had feeling or thought 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 or harm yourself before? ☐ Yes ☐ No

If Yes, how and when?

_____

Psychiatric History Have you previously had therapy or psychiatric care? ☐ Yes ☐ No

Have you ever completed neuropsychological assessment? ☐ Yes ☐ No

If yes, please describe:

By Whom Reason Dates treated Where

_____

_____

Have you been hospitalized for psychiatric reasons? ☐ Yes ☐ No If yes, please describe:

By Whom Reason Dates treated Where

_____

_____

Have you had electroconvulsive therapy (ECT) or transcranial Magnetic stimulation (TMS)? ☐ Yes ☐ No

If yes, please give dates:

_____

Do you have a history of sleep apnea? ☐ Yes ☐ No

If yes, has it been treated: _____

Personal and Family Psychiatric History Checklist

	You	Formally Diagnosed/ Treated (Y/N)	Family Member(s)? Relationship to You	Formally Diagnosed/ Treated (Y/N)
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				

Substance Use

Do you currently use:	Y/N	How much?	How often?	Date last used?	Have you ever used?	Have you ever had treatment?
Alcohol						
Tobacco						
Marijuana						
Cocaine						
Methamphetamines						
Heroin/Opiates						
Others including Rx overuse/abuse:						

Legal History Any current pending legal problems? ☐ Yes ☐ No If yes, please explain:_____

Any charges other than for minor traffic violations? ☐ Yes ☐ No If yes, please explain:_____

Occupational History Highest level of education or degree obtained: _____

Are you currently? ☐ Retired ☐ Working ☐ Unemployed ☐ Disabled

Current/Former most important Occupation?_____

Are you a veteran? ☐ Yes ☐ No If yes, what branch and when? _____

Current/Former volunteer? ☐ Yes ☐ No If yes, what and when? _____

Current hobbies/activities: _____

Former hobbies/activities: _____

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)? _____

Do you have grandchildren? ☐ Yes ☐ No

How would you describe your relationship with your children? Grandchildren? _____

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Living Situation Are you currently satisfied with your living environment? ☐ Yes ☐ No

Currently living: ☐ Home, alone ☐ Home, with partner ☐ Home, with caregiver/family assistance

Long term care setting: ☐ Independent Living ☐ Assisted Living ☐ Skilled Nursing ☐ Memory Care

Do you currently have a paid/personal caregiver? ☐ Yes ☐ No If yes, for what? For how long?

_____

Do you or family/caregivers have concerns about your memory, thinking, or ability to make decisions?

☐ Yes ☐ No If yes, please explain: _____

While you were growing up, during the first 18 years of life:

1. Did a parent or another adult in the household <u>often</u>:
   Swear at you, insult you, put you down, or humiliate you?
   Or
   Act in a way that made you afraid that you might be physically hurt?
   ☐ Yes ☐ No

2. Did a parent or other adult in the household <u>often</u>:
   Push, grab, slap, or throw something at you?
   Or
   Ever hit you so hard that you had marks or were injured?
   ☐ Yes ☐ No

3. Did an adult or person at least 5 years older than you <u>ever</u>:
   Touch or fondle you or have you touch their body in a sexual way?
   Or
   Attempt or actually have oral, anal or vaginal intercourse with you?
   ☐ Yes ☐ No

4. Did you <u>often</u> feel that:
   No one in your family loved you or thought you were important or special?
   Or
   Your family didn't look out for each other, feel close to each other, or support each other?
   ☐ Yes ☐ No

5. Did you <u>often</u> feel that:
   You didn't have enough to eat, had to wear dirty cloths, and had no one to protect you?
   Or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   ☐ Yes ☐ No

6. Were your parents ever separated or divorced:
   ☐ Yes ☐ No

7. Were any of your parents or other adult caregivers:
   Often pushed, grabbed, slapped, or had something thrown at them?
   Or
   Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
   Or
   Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?

8. Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?
   ☐ Yes ☐ No

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?
   ☐ Yes ☐ No

10. Did a household member go to prison?
    ☐ Yes ☐ No

List ALL current medications, over-the-counter medications and/or supplements: (use other side if needed)

MEDICATION	DOSE	Estimated Start Date

Please circle any psychiatric medications you have taken in the past:

Depression/Anxiety Medications:

Prozac (fluoxetine)	Zoloft (sertraline)	Paxil (paroxetine)	Luvox (fluvoxamine)
Celexa (citalopram)	Lexapro (escitalopram)	Viibryd (vilazidone)	Brintellix/Trintellix (vortioxetine)
Wellbutrin (bupropion)	Remeron (mirtazapine)	Deplin	Fetzima (levomilnacipran)
Effexor (venlafaxine)	Pristiq (desvenlafaxine)	Cymbalta (duloxetine)	Serzone (nefazodone)
Elavil (amitriptyline)	Pamelor (nortriptyline)	Tofranil (imipramine)	Anafranil (clomipramine)
Parnate (tranylcypromine)	Nardil (phenelzine)	Emsam (selegiline)	desipramine
Buspar (buspirone)	Vistaril (hydroxyzine)	Indural (Propanolol)	Tranxene (clorazepate)
Xanax (alprazolam)	Ativan (lorazepam)	Klonopin (clonazepam)	Valium (diazepam)

Mood Stabilizers/Antipsychotic Medications:

Tegretol (carbamazepine)	Trileptal (oxcarbazepine)	Depakote (valproate)	Lithium
Lamictal (lamotrigine)	Topamax (topiramate)	Neurontin (gabapentin)	Lyrica (pregabalin)
Seroquel (quetiapine)	Zyprexa (olanzepine)	Saphris (asenapine)	Clozaril (clozapine)
Abilify (aripiprazole)	Rexulti (brexpiprazole)	Risperdal (risperidone)	Invega (paliperidone)
Latuda (lurasidone)	Geodon (ziprasidone)	Fanapt (iloperidone)	Haldol (haloperidone)
Thorazine (chlorpromazine)	Prolixin (fluphenazine)	Trilafon (perphenazine)	

Sedatives:

trazodone (Desyrel)	Rozerem (ramelteon)	Restoril (temazepam)	Chloral hydrate
Ambien (zolpidem)	Lunesta (eszopiclone)	Belsomra	

ADHD/Dementia/Other Medications:

Strattera (atomoxetine)	Artane (trihexylphenidyl)	Adderall/XR	Nuedexta
Intuniv (guanfacine)	Provigil (modafinil)	Nuvigil (armodafinil)	Chantix
Aricept (donepezil)	Exelon (rivastigmine)	Razadyne (galantamine)	amantadine
Namzaric (donepezil/namenda)		Cogentin (benztropine)	Vyvanse
Namenda (memantine)	Ritalin/Concerta/Focalin/Datrana (methylphenidate)		

Is there anything else about your history that is important for us to know at this time? If so, please explain:

_____

_____

Please complete scales on next pages.

If patient has dementia please skip to caregiver questions on page 9

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Over the last *2 weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns		+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

TOTAL:

10. If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____
Somewhat difficult _____
Very difficult _____
Extremely difficult _____

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The following are supplemental questions about cognition symptoms for a family member or close friend to complete. If there are no cognitive concerns please leave blank.

MEMORY AND THINKING – DOES SHE/HE HAVE PROBLEMS WITH: mark with an X

	Never	Sometimes	Often	Always
Recalling recent events				
Repeating questions or stories				
Misplacing items				
Forgetting dates or appointments				
Speaking or understanding				
Giving up or withdrawing from activities				
Recognizing familiar places, people, or objects				
Recalling events in the past				
Using the telephone				
Shopping				
Preparing food				
Housekeeping				
Doing laundry				
Driving or arranging for transportation				
Taking medications				
Handling money				
Using technology (tools, microwave, computer, thermostat, etc.)				
Walking Have they had falls? ☐ Yes ☐ No				

PERSONAL CARE AND GROOMING – DOES SHE/HE HAVE PROBLEMS WITH:

	Completely Independent	Verbal Reminders	Physical Assistance	Completely Dependent
Shaving				
Combing/styling hair				
Brushing teeth				
Applying or removing makeup, if applicable				
Bathing or showering				
Dressing or undressing				
Eating, using utensils				
Chewing and swallowing correctly/safely				
Using the toilet				

MOOD AND BEHAVIOR – Please answer the following questions based on changes that have occurred since the patient first began to experience memory problems. Check if the symptom(s) has been present <u>in the last month</u>.

	Not Applicable	Mild	Moderate	Severe
DELUSIONS Does the patient believe that others are stealing from them? Planning to harm them in some way?				
HALLUCINATIONS Does the patient act as if they hear voices? Talk to people who are not there?				
AGITATION Is the patient stubborn or resistant to help?				
DEPRESSION Does the patient act as if they are sad? Often cry?				
ANXIETY Does the patient become upset or nervous when separated from you? Anxious generally?				
EUPHORIA Does the patient appear to feel too good or act excessively happy?				
APATHY Does the patient seem less interested in his or her usual activities or in the activities of others?				

DISINHIBITION Does the patient act impulsively, talking to people they don't know or saying hurtful things?				
IRRITABILITY Is the patient impatient or cranky? Have difficulty coping with delays or waiting for planned activities?				
HYPER-ACTIVITY Does the patient engage in repetitive activities, such as pacing around the house, handling buttons, wrapping string, other repetitive things?				
SLEEP PROBLEMS Does the patient awaken you/others during the night, rise too early in the morning, or take excessive naps during the day?				
EATING HABITS Has the patient lost or gained weight, or had a change in the food he or she likes?				

Does the person currently drive a motor vehicle? ☐ Yes ☐ No
If he/she drives, are you concerned about his/her safety? ☐ Yes ☐ No