Patient Label

PHRMH Behavioral Health
814 13th St Hood River, OR 98648
(541) 387-6138 (Phone)
(971) 712-2139 (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? ____

____

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	Restricted eating	0	1	2	3	4
Spells of terror or panic	0	1	2	3	4	Purging via laxatives or excessive exercise	0	1	2	3	4
Heart pounding or racing	0	1	2	3	4	Feeling others are unsympathetic	0	1	2	3	4
Checking, rechecking things	0	1	2	3	4	Fear of being abandoned by others	0	1	2	3	4
Feeling the need to count things	0	1	2	3	4	Pattern of relationship problems	0	1	2	3	4
Gambling	0	1	2	3	4	Feeling easily irritated and annoyed	0	1	2	3	4

Updated 3/10/2020

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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)

☐ African American/Black

☐ Alaska Native/Native American

☐ Asian or Asian Indian

☐ Hispanic/Latino

☐ Native Hawaiian/Pacific Islander

☐ Middle Eastern

☐ White

☐ Prefer not to say

☐ 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			