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In order to provide the most effective and comprehensive services possible, please complete the following packet as thoroughly and accurately as possible.

Patient Information

Name: _____ Date: _____
(Last) (First) (Middle Initial)

Date of Birth: _____ Age: _____ Gender: _____ Race: _____

Social Security Number: _____

Marital Status: Single Married Divorced Separated Widowed

Address: _____

City: _____ State: _____ Zip: _____

Day Time Phone: _____ May we leave a message? ☐ Yes ☐ No

Alternate Phone: _____ May we leave a message? ☐ Yes ☐ No

E-Mail: _____

Whom may we thank for referring you to this office? _____

Please state in your own words why you have come to this office today:

_____

_____

_____

_____

Please check ALL of the following symptoms or thoughts that apply to you **AT THIS TIME or during the past six months.**

- ☐ Depressed mood
- ☐ Diminished interests or pleasure
- ☐ Sleep disturbance
- ☐ Fatigue
- ☐ Change in appetite
- ☐ Hopelessness
- ☐ Pleasure in few activities
- ☐ Weight change
- ☐ Agitation
- ☐ Excessive worry
- ☐ I feel like I am losing control.
- ☐ Irritability
- ☐ Poor Concentration
- ☐ Tension
- ☐ Feelings of panic
- ☐ Socially withdrawn
- ☐ Use of alcohol
- ☐ Use of other drugs
- ☐ Use of tobacco
- ☐ Anxiety in social settings
- ☐ Makes careless mistakes
- ☐ Does not complete tasks
- ☐ Difficulty organizing
- ☐ Forgetful
- ☐ Confusion

- □ Disorientation
- □ Compulsive checking / counting
- □ Indecisiveness
- □ People talk about me.
- □ Some people want to hurt me.
- □ I feel emotionally distant from others.
- □ I hear voices or sounds others do not hear.
- □ I see things others do not see.
- □ I smell things others do not smell.
- □ Racing thoughts
- □ I do risky or dangerous things.
- □ Little interest in sexual activity
- □ Sexual problems
- □ Gender concerns
- □ I don't like my body.
- □ Binge eating
- □ Self-induced vomiting
- □ Laxative abuse
- □ Excessive fasting
- □ Intense fear of weight gain
- □ Impulsive
- □ I think about hurting myself.
- □ I have tried to hurt myself.
- □ Sometimes I wish I were dead.
- □ I think about hurting someone else.
- □ Exposed to a significant traumatic event
- □ Recurrent distressing dreams

Psychiatric History

I have received treatment for: ☐ Substance abuse ☐ Mental health issues ☐ Both

The treatment occurred at: ☐ Private psychiatrist ☐ Private counselor/therapist

☐ Hospital ☐ Mental Health Center

☐ Other

Are you presently being treated? Yes ☐ No ☐ If yes, by whom? _____

Medical History

Name of your primary care doctor _____

Phone: _____ Date last seen: _____

Do you have a history of any medical problem? ☐ Yes ☐ No

If yes, what _____

Are you presently being treated for any medical problem? ☐ Yes ☐ No

If yes, what _____

Past surgeries: _____

_____

Have you ever received treatment for any of the following medical conditions?

- □ Neurological impairment
- □ Asthma
- □ Seizure disorder
- □ Emphysema
- □ Visual loss / impairment
- □ Chronic bronchitis
- □ Hearing loss / impairment
- □ Tuberculosis / +PPD
- □ Dementia
- □ Cancer
- □ GI disorder
- □ Thyroid disease
- □ Obesity Diabetes
- □ Significantly underweight
- □ Pregnancy
- □ Cirrhosis
- □ Irregular menstrual periods
- □ Hepatitis
- □ Musculoskeletal condition
- □ Heart condition
- □ HIV / AIDS / Related condition
- □ Hypertension
- □ Other

Please list any medications you are presently prescribed.

_____

_____

_____

Relationship and Current Family

Are you currently married or involved in an intimate relationship? ☐ Yes ☐ No

If yes, Name: _____ How long? _____

What is your spouse/significant other's occupation? _____

Have you had any prior marriages? ☐ Yes ☐ No

If yes, how many and how long for each: _____

Do you have any children? ☐ Yes ☐ No

If yes, list ages and gender from oldest to youngest: _____

_____

Educational History

Did you graduate high school? ☐ Yes Where: _____ Year? _____

☐ No Last grade completed? ____ Where? _____Year?_____

Are you currently enrolled in school? ☐ Yes ☐ No

If yes, where? _____

Did you attend college? ☐ Yes ☐ No

If yes, highest degree obtained? _____ Major? _____ Where: _____ Year: ____

Employment History

Are you currently: ☐ Working ☐ Student ☐ Unemployed ☐ Disabled ☐ Retired

How long in your present position? _____

What is/was your occupation? _____ Name of employer: _____

Have you ever served in the military? ☐ Yes ☐ No

If yes, what branch? _____ When? _____

Honorable discharge? ☐ Yes ☐ No ☐ Other Discharge

Thank you for your cooperation and patience. Dr. Pierce will see you shortly and discuss these and other issues in greater detail and help you develop a treatment plan to effectively deal with these issues.