WVU Medicine
Behavioral Medicine and Psychiatry
2004 Professional Court
Martinsburg, WV 25401
Phone: (304) 596-5780 Fax: (304) 596-5781
uhpbehavioralhealth@wvumedicine.org

PATIENT HISTORY FORM

Patient's Name: _____ Todays Date: _____

Date of Birth: _____

Main reason for your visit: _____

I would like to receive the following (*circle all that apply*):

INDIVIDUAL THERAPY PSYCHOLOGICAL TESTING COUPLES THERAPY FAMILY THERAPY GROUP THERAPY

Current Symptoms Checklist:

( ) Depressed Mood	( ) Racing thoughts	( ) Excessive worry	( ) Anxiety Attacks
( ) Unable to enjoy activities	( ) Impulsivity	( ) Sleep pattern disturbance	( ) Avoidance
( ) Increase in risky behavior	( ) Hallucinations	( ) Loss of Interest	( ) Increased libido
( ) Concentration/forgetfulness	( ) Decreased need for sleep	( ) Suspiciousness	( ) Change in appetite
( ) Excessive guilt	( ) Excessive Energy	( ) Fatigue	( ) Increased irritability
( ) Decreased libido	( ) Crying spells	( ) Other_____	

Past Mental Health History:

Outpatient treatment ( ) Yes ( ) No If yes, please describe when, by whom and nature of treatment.

Reason Dates Where

_____

_____

_____

Psychiatric Hospitalization: ( ) Yes ( ) No If yes, please describe for what reason, when and where.

Reason Date Where

_____

_____

Developmental History:

Where there any complications with your mother's pregnancy or with your birth, or were you born prematurely?
( ) Yes ( ) No ( ) Unsure

Did you experience any difficulty learning to walk, talk, read, write or reach any other developmental milestone(s)?
( ) Yes ( ) No ( ) Unsure

Was there any type of child abuse in your family?
( ) Yes ( ) No ( ) Unsure

How many siblings do you have? _____

How would you describe your childhood?

_____

Educational History

Were you ever formally tested for and/or diagnosed with a learning disability? ( ) Yes ( ) No ( ) Unsure
If "yes", please explain: _____

How many years of education have you completed? _____

Social History

Have you ever experienced a traumatic event like being robbed, assaulted, raped or having been in combat? ( ) Yes ( ) No ( ) Unsure

If "yes", please explain: _____

Are you involved in any lawsuit or legal matter with whom you want the doctor's help by sending reports, evaluations, etc. to an attorney or to the court? ( ) Yes ( ) No

If "yes", please explain: _____

Have you ever had legal problems, arrests, been in jail or prison? ( ) Yes ( ) No

If "yes", please explain: _____

Please list anything else you think is important for your provider to know about your psychological or social history:

_____

_____

Medical History

Which of the following conditions are you currently being treated or have been treated for in the past? (Please Check)

General Medical:

( ) Heart disease	( ) Shortness of breath	( ) Eye disorder/Glaucoma	( ) Diabetes
( ) Atrial Fibrillation	( ) COPD/emphysema	( ) Osteoarthritis	( ) Colitis
( ) Heart Attack	( ) Thyroid Problems	( ) Ear Problems	( ) Ulcer
( ) High cholesterol	( ) Liver problems/ Hepatitis	( ) Swollen Ankles	( ) Asthma
( ) Kidney/bladder problems	( ) High blood pressure	( ) Lung problems/cough	( ) Stroke
( ) Low blood pressure	( ) Sinus problems	( ) Headaches/Migraines	( ) Seizures
( ) Heartburn (reflux)	( ) Seasonal Allergies	( ) Arthritis	
( ) Anemia or blood problems	( ) Tonsillitis	( ) Ulcers/colitis	

( ) Other_____

Neurological:

( ) Memory Problem	( ) Alzheimer's Disease	( ) Lewy Body Disease
( ) Parkinson's Disease	( ) Vascular Dementia	( ) Fronto-temporal Dementia
( ) Multiple Systems Atrophy	( ) Huntington's Disease	( ) Progressive Supranuclear Palsy
( ) ALS (Lou Gherig's Disease)	( ) Essential Tremor	( ) Dystonia
( ) Multiple Sclerosis	( ) Head or Brain Injury	( ) Epilepsy or other seizure disorder
( ) Stroke		

Cancer:

( ) Breast Cancer	( ) Prostate Cancer	( ) Lung Cancer
( ) Ovarian Cancer	( ) Brain Cancer	( ) Radiation
( ) Cervical Cancer	( ) Other (type:)	( ) Chemotherapy

Sleep:

( ) Restless Leg Syndrome	( ) Insomnia	( ) Nightmares
( ) REM Sleep Behavior Disorder	( ) Sleep Apnea	( ) Narcolepsy
( ) Periodic Limb movements		

Mind-Body, Auto-Immune and Immune-Deficiency:

( ) Lupus	( ) Irritable Bowel Syndrome	( ) Psychogenic seizure (non-epleptic seizures)
( ) Psychogenic movement disorder	( ) Other conversion disorder	( ) Chronic Fatigue Syndrome/SEID
( ) Fibromyalgia	( ) Endometriosis	( ) Rheumatoid Arthritis
( ) HIV	( ) AIDS	

Other-Gynecological:

( ) Infertility	( ) Abnormal PAP	( ) Menopause
( ) Sexually transmitted Disease	( ) Miscarriage	( ) Loss of Infant

Have you ever had a concussion, head injury, brain injury, seizures or loss of consciousness?

( ) Yes ( ) No ( ) Unsure

If "yes", please explain: _____

Have you ever undergone an evaluation of your memory, thinking or other cognitive/mental abilities before?

( ) Yes ( ) No ( ) Unsure

If "yes", where, when and with whom? _____

What was the diagnosis as you remember it? _____

Has a doctor ever told you that you should not drive? _____

Please list your surgical history:

_____

_____

Family Psychiatric History: Has anyone in your family been diagnosed with or treated for:

( ) Post Traumatic Stress	( ) Alcohol abuse	( ) Depression	( ) Anger
( ) Substance Abuse	( ) Schizophrenia	( ) Bipolar disorder	( ) Violence
( ) Anxiety	( ) Suicide	( ) ADHD	( ) Other

Suicide Risk Assessment:

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

If NO, please skip to next page. If YES, Please answer the following:

- Do you currently feel that you do not want to live? ( ) Yes ( ) No
- How often do you have these thoughts? _____
- When was the last time you had thoughts of dying? _____
- What (if anything) happened recently to make you feel this way? _____
- On a scale of 1 – 10 (ten being the strongest) how strong is the desire to kill yourself currently? _____
- Over the last month, indicate the highest level of desire to kill yourself (1-10) that you have experienced. _____
  - When did this happen? _____
- What decreases the desire and helps you feel better? _____
- Have you ever thought about how you would kill yourself? If YES, what is the method? _____
- Is the method you would use readily available? _____
- Have you planned a time for killing yourself? If YES, when? _____
- What would stop you from killing yourself? _____
- Do you feel hopeless and/or worthless? _____
- Have you ever had thoughts of harming yourself even if you did not want to actually end your life? _____
- Have you ever tried to kill or harm yourself in the past? If YES, when was the most recent time? _____
  - Please describe what happened: _____

_____

** If you are in a crisis (suicidal), please go to the Emergency Department at the nearest hospital or dial 9-1-1*

Substance Use:

Have you ever been treated for alcohol or drug use or abuse? ( ) Yes ( ) No

If yes, for which substance? _____

If yes, where were you treated and when? _____

How many days per week do you drink any alcohol? _____

What is the least number of drinks you will drink in a day? _____

What is the most number of drinks you will drink in a day? _____

In the past 3 months, what is the largest amount of alcoholic drinks you have consumed in one day? _____

Have you ever felt you should cut down on your drinking or drug use? ( ) Yes ( ) No

Have you ever felt bad or guilty about your drinking or drug use? ( ) Yes ( ) No

Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? ( ) Yes ( ) No

Do you think you may have a problem with alcohol or drug use? ( ) Yes ( ) No

Have you used street drugs in the past 3 months? ( ) Yes ( ) No

If yes, which ones and for how long? _____

Have you abused prescription medications? ( ) Yes ( ) No

If yes, which ones and for how long? _____

Check if you have ever tried any of the following:

( ) Methamphetamine ( ) Cocaine ( ) Stimulants ( ) Heroin ( ) Hallucinogens / LSD
( ) Marijuana ( ) Ecstasy ( ) Methadone ( ) Alcohol ( ) Pain killers (not prescribed)
( ) Tranquilizer/sleeping pills ( ) Other _____

_____

_____

Tobacco History:

Have you ever smoked cigarettes? ( ) Yes ( ) No

Do you currently smoke? ( ) Yes ( ) No

If yes, how many packs per day on average? _____

How many years have you smoked? _____

In the past? ( ) Yes ( ) No

How many years did you smoke? _____

When did you quit? _____

Have you ever used smokeless tobacco (chewing tobacco)? ( ) Yes ( ) No