Behavioral Health Associates of Western New York

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Adult Psychosocial/Health Screening Questionnaire

We ask that you fill out the following paperwork **as completely as possible**. Your cooperation is necessary and much appreciated.

The purpose of this is to gather as much pertinent clinical history as possible so that the doctor treating you can have a full understanding of your development and presenting problems.

Please keep in mind that some of the questions asked may not pertain to you, yet they are important parts of a thorough evaluation. This evaluation is for the doctor to review. This form will not be sent to other agencies, but with your permission, a summarized dictation will be sent to treatment providers for continuity of care.

NAME:____GENDER: M/F

MARITAL STATUS: Single/Married/Divorced/Separated/Widowed/Living with DOB: ________________

Significant Other/Wife/Husband: Name: ____

You live in (please check): _____home _____apartment _____room ______other

EMERGENCY CONTACT'S NAME:____

Home:____________________________________ Cell:______________________________

Work:____________________________________ Emergency:____

SIBLINGS: (Give names, ages, and relationship with you - i.e., fair, poor, good, close, etc.)

____

____

____

____

FRIENDS: (List a few with duration and type or relationship with you)

____

____

____

Is there someone you can talk to whenever you need to? Y/N

HPI

1. Please describe the problems that led you into treatment, and in particular, what led you to come at this time.

___

___

___

2. Have you ever threatened to hurt yourself? Yes_____No_____

Describe___

___

3. Have you ever intentionally hurt yourself or attempted suicide? Yes_____No_____

Describe___

___

4. Please check any of the following that apply, indicating whether the problem is "Now," "Past," or both. When given a choice ("A"/ "B"), circle the one which bother you most.

PROBLEM	NOW	PAST	PROBLEM	NOW	PAST
Slowed movement			Feeling:		
Agitated movement			Dizzy/faint		
Feelings of: Helplessness/hopelessness			Choking		
Guilt/depression			Nausea/abdominal distress		
Fatigue/loss of energy			Detached for self/unreality		
Weight gain/increased appetite How much? _____			Losing control/going crazy		
Weight loss/decreased appetite How much? _____			Numbness/tingling		
Sleep problems: Too little			Sweating/clammy hands		
Too much			Trembling/shaking		
Hearing voices			Fear of dying		
Feelings of being watched			Hot flashes/chills		
Shortness of breath/smothering			Worry/anxiety		
Heart palpitations/pounding racing			Irritability		
Chest pain/discomfort			Social isolation		

			Unable to function		

5. Have you ever experienced any of the following symptoms during a distinct period of time one week or longer in which you also felt very elated or irritable?

PROBLEM	NOW	PAST
Decreased need for sleep		
More talkative or feelings pressure to keep talking		
Feeling that your thoughts are racing or changing quickly		
Feelings of inflated self-esteem or self-worth		
Being easily distracted		
Increased activity (socially, at school or work, or sexually)		
Agitation		
Engaging in behaviors that have painful consequences (such as buying sprees, sexual indiscretions, or risky business investments)		

6. Recent Stressful Life Events
Check any of the following that have occurred in the last 2 years:

Married ☐
Engaged ☐
Separated ☐
Divorced ☐
Serious argument ☐
Loss of important relationship ☐
Child left home ☐
Death of spouse, other ☐
Bad health of family member ☐
Difficulties with family member ☐
Personal injury, illness ☐
Sexual difficulties ☐
Changes, problems at school, work ☐
Retired, or lost job ☐
Changed residence ☐
Legal difficulties ☐
Multiple traffic tickets ☐
Financial problems, owe money ☐

Past Psychiatric History

1. Have you been in **outpatient therapy** for behavioral/emotional problems in the past or currently (include alcohol and/or drug treatment)? Yes_____ No_____
* If yes, please specify where, approximate dates and the effectiveness of the treatment.

Treatment Provider	**Dates**	**Effectiveness**

The diagnosis given to me was ____

2. Have you been **an inpatient in a hospital ward** for treatment of behavioral/emotional problems in the past?
Yes_____ No_____
* If yes, please specify where, approximate dates and the effectiveness of the treatment.

Treatment provider	Dates	Effectiveness

3. Have you taken medication in the past for behavioral/emotional problems?
Yes _____ No_____
* If yes, please list them, describe the effectiveness and list doses, as well as any side effects if recalled.

Medication	Dose	Side Effects	Effectiveness

4. Are you taking any medications at this time for behavioral or emotional problems?
Yes_____ No_____
* If yes, please list the names of the medication and dosage.

Medication	Dose

Are the medications secured? Yes_____No_____

Explain:____

Medical History
Please list the name and phone number of your physician.
Name/phone number:____

1. Do you have any allergies to medication or environmental allergies? Yes_____No____
* If yes, please list them as well as the **specific reaction**.

Allergy (Medication/Environmental)	Reaction

2. Do you have any medical problem for which you are followed? Yes_____No_____
Have you ever had a severe head injury or seizures? Yes_____No_____
Explain:____

____

3. Have you ever been admitted to a hospital because of medical problems, including illness or injury?
Yes_____No_____
*If yes, please provide details including the reason for admission, your age at the time of admission and the outcome.

Hospital	**Date**	**Age**	**Reason**	**Outcome**

4. Are you taking any prescription or over-the-counter medications for a medical condition at this time (include contraception)? Yes_____No_____

Medication	**Dose**

5. Have you had **surgery** for any reason? Yes_____No_____
*If yes, please provide details including the surgical procedure, age of the child at the time of admission and outcome.

Surgery	**Age**	**Outcome**

6. Has any physician ordered blood work, special testing, CT/MRI recently? Yes_____No_____

Review of Systems
Do you have or have you ever had any problems as described below?
*If yes, please provide details.

	Yes	**No**	**Comment**
General weight loss			
Fever, sweating			
Recent illness (including strep)			
History of exposure to toxins/lead			

Skin condition			
Head injury			
Frequent headaches			
Vision problems			
Hearing problems			
Dental problems			
Asthma/shortness of breath			
Heart condition			
Stomach/gastrointestinal problems			
Hepatitis/jaundice			
Frequent urinary tract infection (bladder infection)			
Bed wetting			
Sleep problems			
Accidental bowel movement			
Joint pain/swelling			
Muscle pains			
Seizures			
Muscle twitches/tics			
Bleeding problems/easy bruising			
Anemia			
Endocrine problems (diabetes, thyroid, problems with menses)			

During what hours do you sleep?____

Developmental History

Please answer the following questions about your development:

a. Who was involved in taking care of you in the first three years of life?

____

b. Were you separated from the primary care giver for any length of time?
Yes _____ No_____
Describe: ____

c. Did you bond well with your mother? Yes_____ No_____
Describe:____

____

d. Did you bond well with your father? Yes _____ No_____
Describe:____

____

e. During any time in your life, have you been a victim of physical or sexual abuse
to your knowledge? Yes _____ No_____
Describe:____

____

f. Have you ever been exposed to potentially traumatic events such as severe accidents to self or others, domestic violence, police involvement with family etc?
Yes _____ No _____ Explain:____

____

g. Has Child Protective Services ever been involved with your family? Yes _____ No_____
Explain: ____

____

Circle if during childhood/adolescence you:

Were afraid to go to school
Had difficulty with basic subjects
Were truant
Failed or repeated a grade
Had frequent falls
Were awkward at games
Wet bed after age 5
Had motor/vocal tics
Had speech problems

Had nightmares
Were afraid of the dark
Ran away from home
Were cruel to animals
Frequently lied to others
Set fires
Moved frequently
Were exposed to incest
Were promiscuous

Brief explanation of above:____

____

____

School History

Education: Please check the highest level completed:

___6th or less ___7th ___8th ___9th ___10th ___11th ___12th
College: ___1 ___2 ___3 ___4 ___Graduate School?

If you have a Degree, what is it in?____

Social History

1.

Marriage(s)	How Long	How Ended (Sep/Div/Annul/Death)	Comments
None	XXX	XXX	XXX
First			
Second			
Third			

2.

Children: Name	Male/Female - M or F	Date of Birth	With whom does child reside?

(Use back of page if more room necessary.)

3. Have you (or spouse) every had any: (Please check all that apply.)

☐ Miscarriages ☐ Abortions ☐ Still Births ☐ Adoptions

Comments:____

____

____

4. Please list others currently living with you (except children already listed above).

Name of person(s) living with you:	Relationship to you:

Employment History

5.

Employer's Name	Address	Position	From	To

Describe any problems related to employment:____

____

____

Arrest History

6. Please list any time(s) you have been arrested (Use back of page if needed).

Date	Charges	Results

Are you presently involved in any legal problems? Y/N

Check any that may apply:

☐	DWI	☐	Charges pending	☐	Custody problems
☐	Law suites	☐	SSI/SSD Appeals	☐	Other:_______________________________

7. Do you have access to or do you own any firearms? Yes_____No_____

Substance Abuse History

8. Please check any substance you have taken: (All information is confidential)

Substance		Quantity/Time (Example: "6 beers/day")	Past or Current?
None	☐	_________________________________	______________________
Nicotine	☐	_________________________________	______________________
Caffeine	☐	_________________________________	______________________
Alcohol	☐	_________________________________	______________________
Amphetamines (speed)	☐	_________________________________	______________________
Barbiturates (tranquilizers)	☐	_________________________________	______________________
Cocaine/crack	☐	_________________________________	______________________
Heroin	☐	_________________________________	______________________
Inhalants	☐	_________________________________	______________________
Laxatives	☐	_________________________________	______________________
LSD/Hallucinogens	☐	_________________________________	______________________
Marijuana/Hashish	☐	_________________________________	______________________
Pain killers (Percodan, etc)	☐	_________________________________	______________________
Other:________________	☐	_________________________________	______________________

Family History

1. Has any member of the immediate family or extended biological family ever suffered from any type of mental illness or disruptive behavior problems? (Please include both the biological mother and father's family history including history of):

History of	Yes	No	Describe
Depression			
Bipolar disorder/Manic Depression			
Suicide/Suicide Attempt			
Anxiety			
Obsessive Compulsive Disorder			
Attention Deficit Disorder			
Dementia/Alzheimer's			
Psychosis/Schizophrenia (hearing things/delusions)			
Alcohol Problems			
Illegal Drug Problems			
Arrests/Criminal Behavior			
Abuse			
Learning Problems			
Autism			
Tourette Disorder			
Eating Disorder (Anorexia/Bulimia)			
Personality Disorder			

2. Has any member of the immediate or biological family ever suffered from any type of medical illness?

Yes _____ No _____

a. Please describe what illness and how they are related? ____

____

Thank you for your time.