Name: _____

Date of Birth: _____ Social Security Number_____

Address: _____

_____

Phone Numbers:
Home_____Mobile_____

Email Address_____

Referred by: _____

In Case of Emergency who would you like me to contact?

If you have OSU insurance I will need all information also bring your card to your initial appointment.

Policy holder_____ Policy #_____

Group #_____ Policy holder date of birth_____

Family Physician/Internist: _____

Address: _____

Phone: _____

Employment or Student Status:

Employer: _____

Job Title: _____

College or University: _____Year: _____

Spouse or Partner:_____

What is the main problem (s) for you at this time?

What have you tried to solve this problem?

What has helped?

Are you currently receiving treatment for this problem? Yes No

If yes, describe: _____

Past or Current Mental Health Services

Therapy: _____

Past Medications:_____

_____

_____

Name of Therapist: _____

Hospitalizations: Dates /Name of Hospitals_____

_____

Circle any life stresses that might have brought on or added to your problems:

Financial pressure legal problems move(s) job change(s) Divorce

Separation Marriage or new relationship birth of child

conflicts in marriage or relationship Medical problems death(s)

traumatic experiences Other:_____

_____

Please check any of the following that are problems for you:		
	X	Comments
Feelings of sadness, depression		
Difficulty handling anger		
Feeling very nervous		
Panic		
Difficulty with sleep		
Difficulty with eating, appetite		
Being very irritable, edgy		
Crying too easily		
No energy		
Unable to enjoy anything		
Difficulty concentrating or memory		
Thinking about death		
Thinking about suicide		
Thinking about hurting someone		
Annoying thoughts that won't go away		
Excessive worries		
Annoying habits or behaviors		
Hearing voices		
Feeling confused		
Feeling out of control		
Concern about weight		
Concern about appearance		
Difficulty with friends		
Difficulty with spouse or partner		
Difficulty with children		
Difficulty with parents		
Difficulty with brothers or sisters		
Difficulty with co-workers or boss		
Unhappy with job/school		
Other		

Medical History

Check and describe any of the following conditions you now have or have had in the past:		
Problem	X	Description of Problem
Allergies to Medicines		
Serious Drug Reaction		
Diabetes		
Thyroid Condition		
Head Injuries (list all)		
High Blood Pressure		
Heart Condition		
Asthma, Bronchitis		
Emphysema/ COPD		
Cancer		
Stomach Problems, Ulcer		
Colitis		
Anemia		
Kidney or Bladder Problems		
Headaches		
Menstrual Problems		Date of last menstrual period:
Prostate Problems		
Sexual Problems		
Pregnancy		Number of pregnancies: Number of births:
Vision Problems		
Glaucoma		
Hearing Problems		
Multiple Sclerosis		
Seizures		
Chronic Pain		
HIV Positive		
AIDS		
Tuberculosis		

Hepatitis		
Sexually Transmitted Disease		
Arthritis		
Physical Handicap		
Very Underweight		
Very Overweight		
Hospitalizations		
Surgeries		
Serious Injuries or Accidents		
Fractures (broken bones)		
Other		

List your Current use of :

Medicines now being taken: (include supplements)	
Special Diet:	
Weekly Exercise (time, type)	
Daily Tobacco Use:	
Daily Amount of Caffeine Drinks: (coffee, colas, tea)	
Weekly Use of Alcohol (beer, wine, liquor, Other):	
Weekly Use of Drugs (marijuana, LSD, Other):	

PEOPLE NOW LIVING WITH YOU				
Name	Relation to you	Age	Sex	Grade in School or Years of Education & Occupation

RELATIONSHIPS			
MARRIAGES AND / OR IMPORTANT RELATIONSHIPS			
Spouse or Partner's Name	Year Married or Begun	Year of Separation, Divorce, or Death	Children of Marriage or Relationship – List Names and Year of Birth

FAMILY MENTAL HEALTH HISTORY
Check the item if there is any family member with the problem (parents, sisters, brothers, cousins, aunts, uncles, grandparents, etc.)

Illness or Problem	X	Relation to you
Alcoholism		
Drug Abuse		
Other Addictive disorders		
Depression		
Deliberately Harmed Self		
Suicide Attempt		
Suicide		
Attention Problems or “ADD”		
Hyperactivity		
Learning Problems or Dyslexia		
Tics or Tourette’s Disorder		
Autism		
Intellectual/Developmental Disorders		
Obsessive Compulsive Disorder		
Severe Anxiety, Fears, or Phobias		
Panic Attacks		
Manic Depressive or Bipolar disease		
Schizophrenia		
Victim of Physical Abuse		
Victim of Sexual Abuse or Rape		
Post Traumatic Stress Disorder		
Violent or Abusive Behavior		
Violent Sexual Behavior, Rape		
Trouble with the Law		
Other:		

FAMILY MEDICAL HISTORY
Check the item if there is any family member with the problem (parents, sisters, brothers, cousins, aunts, uncles, grandparents, etc.)

Illness	X	Relation to You
Diabetes		
Cancer		
Sudden Death		
Heart Disease		
High Blood Pressure		
Kidney Disease		
Multiple Sclerosis		
Seizures		
Sickle Cell Anemia		
Stroke		
Other		