ASSOCIATES FOR PSYCHIATRIC SERVICES, P.C.

▪ PRE-ASSESSMENT FOR ADULTS ▪

PATIENT NAME _____ DATE OF BIRTH_____

CHIEF COMPLAINT

Briefly state your main problem:_____

_____

Please check any of the following that you have recently had to cope with:

- ☐ Addictive Behavior
- ☐ Anxiety
- ☐ Argue too much
- ☐ Avoid contact with others
- ☐ Can't concentrate
- ☐ Chronic pain
- ☐ Defy requests from others
- ☐ Depression
- ☐ Disorganized
- ☐ Divorce/Separation
- ☐ Doubting my abilities
- ☐ Eating problems
- ☐ Emotional abuse
- ☐ Family conflicts
- ☐ Fatigue
- ☐ Fear of gaining weight
- ☐ Fear of being alone
- ☐ Feel persecuted
- ☐ Financial problems
- ☐ Guilt
- ☐ Hallucinations
- ☐ Headaches
- ☐ Homicidal thoughts
- ☐ Impulsiveness
- ☐ Inappropriate feelings
- ☐ Indecisive
- ☐ Insensitive to others
- ☐ Jealousy
- ☐ Job stress
- ☐ Lack of assertiveness
- ☐ Loneliness
- ☐ Lose temper easily
- ☐ Low self-esteem
- ☐ Low interest in usual activities
- ☐ Lying
- ☐ Marital problems
- ☐ Need reassurances
- ☐ Nightmares
- ☐ Not resolving conflicts
- ☐ Over-dependent
- ☐ Panic attacks
- ☐ Phobic fears
- ☐ Physical abuse
- ☐ Poor parenting skills
- ☐ Problems initiating relationships
- ☐ Problems sleeping
- ☐ Sexual abuse
- ☐ Shame
- ☐ Shyness
- ☐ Speaking problems
- ☐ Stealing
- ☐ Substance abuse
- ☐ Suicidal ideas
- ☐ Unable to relax
- ☐ Unrealistic worrying
- ☐ Other

MEDICAL HISTORY (please circle the things that are currently bothersome to you)

General	Fevers, chills, sweats, lumps, weight loss, weight gain
Head & ENT	Headaches, dizziness, hearing loss, ear pain, ringing, drainage, nosebleeds, vision loss, eye pain, mouth bleeds, sores, voice change
Heart & Lungs	Cough, dark sputum, bloody sputum, shortness of breath, wheezing, need high pillows, awaken at night choking, heart pains, chest pains, swelling of feet, palpitations
GI	Stomach pains, indigestion, gas, nausea, vomiting, constipation, diarrhea, bloody stools, yellow jaundice
GU	Burning urine, bloody urine, infection, VD, difficulty in starting stream, dribbling, get up at night to urinate
Menstrual	Onset age Last period Number of pregnancies
BJM	Stiff joints, joint pains, weakness, bad back, varicose veins, muscle pains
Neurological	Nervousness, paralysis, numbness, fainting, stroke, tensions, tingling
Endocrine	Bleeding, unusual bruising, hair changes, skin changes, heat/cold intolerance, loss of sex drive

Please list all medications you are currently taking:

NAME OF MEDICATION	DOSAGE & FREQUENCY	PRESCRIBING PHYSICIAN

Attach separate sheet if necessary.

Please list any drug allergies or sensitivities that you have:_____

Pharmacy Name:_____ Pharmacy Telephone No:_____

EDUCATIONAL HISTORY

What is the last year of school you attended?_____

Do you have a degree?_____

SOCIAL HISTORY

Do you make friends easily? Yes ☐ No ☐ If no, explain why:_____

_____

What do you do for fun?_____

Do you have any sexual problems or concerns? Yes ☐ No ☐ If yes, explain:_____

_____

At what age did you first have sex?_____

Have you been in trouble with the law? Yes ☐ No ☐ If yes, explain: _____

_____

Do you currently have any legal charges pending? Yes ☐ No ☐ If yes, explain: _____

_____

Do you have a history of abuse? Verbal ☐ If so, by whom_____

Physical ☐ If so, by whom_____

Sexual ☐ If so, by whom_____

Do you currently work outside the home?_____

What other jobs have you held? _____

What is your religious background?_____

How important is this to you?_____

Who currently lives in the home with you?_____

How many times have you been married?_____

How long did (or has) each marriage lasted?_____

Do you have any other significant other in your life?_____

Have you ever used:	**How often do you use now?**	**How much do you usually use?**
Tobacco		
Alcohol		
"Huffing" (gas, paint, glue)		

Marijuana_____

Speed (including "crystal" and "ice")_____

Hallucinogens (LSD, "acid", mushrooms)_____

Cocaine (including "crack")_____

Other (Heroin, Barbiturates, Quaaludes, etc.)_____

FAMILY HISTORY

Please circle:

Mother: ☐ alive ☐ deceased age_____
Father: ☐ alive ☐ deceased age_____

Age of brothers ____ ____ ____ ____ ____
Age of sisters ____ ____ ____ ____ ____
Age of children ____ ____ ____ ____ ____

Have any relatives had:

____Diabetes, thyroid or other gland disease	If so, whom_____
____Alcohol problems	If so, whom_____
____Drug problems	If so, whom_____
____Attention problems	If so, whom_____
____Mental retardation	If so, whom_____
____Behavioral problems	If so, whom_____
____History of seeing a psychiatrist or a counselor	If so, whom_____
____History of being in jail or prison	If so, whom_____
____Depression	If so, whom_____

MISCELLANEOUS

What do you see as your strengths?_____

_____

What do you see as your weaknesses?_____

_____

What are your goals for treatment?_____

_____

FOR OFFICE USE ONLY