Genesis Behavioral Health

New Patient Clinical History

20220324
Adult

Name: _____ **DOB:** _____ **Age:** _____ **Date:** _____

Are you ALLERGIC to any medicines? □ **No** □**Yes List:**_____

How did you hear about us? **If someone referred you, who?** _____

□ Internet □ Insurance company □ Friend □ Therapist □ Physician □ Unsure/Other _____

BACKGROUND INFORMATION

Tell us about your family & living situation

Names of those living in the same household and names of Children & Step Children *not* living with you:

□ No one lives with me. I live alone.

Living with you?	Name	Age	Relationship to you
□Yes □No			
□Yes □No			
□Yes □No			
□Yes □No			
□Yes □No			
□Yes □No			

Are you married? □No □Yes
Have you ever been divorced? □No □Yes
Have you ever been remarried? □No □Yes

Educational, Work, Legal & Religious History

Occupation: _____

Education: Current or highest grade level? _____

Legal: Have you had any legal problems or ongoing problems with custody issues? □ No □ Yes
Describe:_____

Religious Beliefs

Are you a Christian? □ No □ Yes □ Unsure

Other Religious beliefs?_____

How important to you is faith in God:
□ Important □ Somewhat Important □ Not Important

Do you now or have you in the past met with others in religious or spiritual community? □No □Yes

How important is or was this to you?
□ Important □ Somewhat Important □ Not Important

THE PROBLEM WHICH BRINGS YOU HERE:

Why are you here and What are your problems/concerns?
(*Briefly explain the problem that brings you here now and what stressful circumstances have contributed to it.)*

_____

_____

_____

_____

_____

_____

Suicidal Thoughts, Attempts, or Self-harm

CURRENT THOUGHTS OF SUICIDE OR DEATH
☐ I do not think of suicide or death – *if checked, skip this section*
☐ No ☐ Yes - I feel that life is empty or wonder if it's worth living
☐ No ☐ Yes - I have wished I were dead or wished I could go to sleep and not wake up.
☐ No ☐ Yes - I Have been having thoughts of killing myself
☐ No ☐ Yes - I have been thinking about how I might do this.
☐ No ☐ Yes - I am thinking about acting on these thoughts
☐ No ☐ Yes - I have started to work out or have worked out the details of how to kill myself.

PAST SUICIDE ATTEMPTS
☐ NONE ☐ 1 ☐ 2 ☐ 3 or more
SELF MUTILATION
☐ I have not ever hurt myself physically to distract myself from emotional pain – *if checked, may skip to next section*
☐ I used to feel like cutting or hurting myself to deal with emotional pain, b t not any more
☐ Recently I have felt like cutting or hurting myself
☐ I think about cutting or hurting myself several times a day

RAPID MOOD SCREENER

1. Have there been at least 6 different periods of time (at least 2 weeks) when you felt deeply depressed? ☐ No ☐ Yes
2. Did you have problems with depression before the age of 18? ☐ No ☐ Yes
3. Have you ever had to stop or change your antidepressant because it made you highly irritable or hyper? ☐ No ☐ Yes
4. Have you ever had a period of at least 1 week during which you were more talkative than normal with thoughts racing in your head? ☐ No ☐ Yes
5. Have you ever had a period of at least 1 week during which you felt any of the following: unusually happy; unusually outgoing; or unusually energetic? ☐ No ☐ Yes
6. Have you ever had a period of at least 1 week during which you needed much less sleep than usual? ☐ No ☐ Yes

Family History: Do you have any blood relatives with bipolar disorder (or you suspect they might)? ☐ No ☐ Yes

SOCIAL ANXIETY SYMPTOMS	POST-TRAUMATIC STRESS SYMPTOMS
☐ A persistent fear of being embarrassed or looking foolish, especially around unfamiliar people, i.e. very shy	☐ You have experienced a very significant traumatic event. If YES, what?_____
☐ You avoid situations in which you might be embarrassed so much that it interferes significantly with your ability to function normally	☐ Distressing memories or nightmares
	☐ Easily startled, always 'on guard'
OBSESSIVE-COMPULSIVE SYMPTOMS	☐ Feeling numb, unreal, or detached
☐ Do you wash or clean a lot?	☐ You avoid situations reminding you of the trauma
☐ Do you check things a lot?	**EATING ISSUES**
☐ Is there any thought that keeps bothering you that you would like to get rid of but can't?	☐ Constantly dieting despite others saying you're thin
	☐ Binge eating or purging
	OTHER SYMPTOMS
	Are there times that you feel fine one minute and then become tearful (or laughing) the next minute over something small or for no reason at all? ☐Yes

SLEEP ISSUES

Do you generally feel rested when you wake up in the morning? ☐ Yes ☐ No
What time do you typically go to bed? _____ What time do you typically fall asleep? _____
What time do you typically wake up? _____
What time do you typically go to bed? _____ What time do you typically fall asleep? _____
Including naps during the day, how many hours, on average, do you sleep per 24-hour day? _____
If you awaken frequently through the night, how many times do you awaken, and how long does it take you to go back to sleep? If so, you awaken approximately times? _____ Time it takes to get back to sleep: _____
Have you been prescribed CPAP? ☐ Yes If Yes, do you use it regularly? ☐ Yes
Do you work shifts or a nontraditional schedule (could include being a caregiver for infant or elderly)? ☐ Yes

STOP-BANG Sleep Apnea Questionnaire

STOP		
Do you **SNORE** loudly (louder than talking or loud enough to be heard through closed doors)?	Yes ☐	No ☐
Do you often feel **TIRED**, fatigued, or sleepy during the daytime?	Yes ☐	No ☐
Has anyone **OBSERVED** you **stop breathing** during your sleep?	Yes ☐	No ☐
Do you have or are you being treated for **high blood PRESSURE**?	Yes ☐	No ☐

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BANG		
Is your **BMI** more than 35 kg/m^2?	Yes ☐	No ☐
Age – Are you over 50 years old?	Yes ☐	No ☐
NECK – Is your neck circumference > 16 inches?	Yes ☐	No ☐
GENDER – Is your biological gender Male?	Yes ☐	No ☐

TOTAL SCORE		
High risk of sleep apnea: Yes 5-8 Intermediate risk of OSA: Yes = 3-4 Low risk of OSA: Yes = 0-2		

EXERCISE

In a typical week, how many times do you exercise at least 20-30 min (any type, or brisk walking or yoga)?

☐ **Less than once per week** ☐ **1 time** ☐ **2 times** ☐ **3 times** ☐ **4 times** ☐ **5 times** ☐ **6 times** ☐ **7 times**

RELATIONSHIPS AND SOCIAL SUPPORTS

PATIENT INITIALS _____

MARITAL ISSUES/ SIGNIFICANT OTHERS

Are you married? ☐ Yes ☐ No If NO, are you in a steady relationship? ☐ Yes ☐ No

How would you rate your relationship? ☐ Happy ☐ Fairly happy ☐ Just OK ☐ Fairly unhappy ☐ Very unhappy

OTHER CONFLICTUAL RELATIONSHIPS

☐ Yes ☐ No Are you having significant conflict or stress with anyone other than your spouse? If so, who? _____

SOCIAL SUPPORTS

☐ Yes ☐ No Do you experience a lot of loneliness?

☐ Yes ☐ No Do you have a close confidant other than spouse? How often do you talk? _____

JOB

How would you rate your work satisfaction? ☐ Very happy ☐ Fairly happy ☐ Just OK ☐ Fairly unhappy ☐ Very unhappy

PROBLEMS WITH EMOTIONAL INSTABILITY

Having problems with emotional instability means having unstable relationships, low self-esteem, and problems with impulsive behavior, beginning by late adolescence or early adulthood.

Problems with emotional instability – do you tend to:

☐ Make frantic efforts to avoid real or imagined abandonment.

☐ Have a pattern of difficult relationships caused by alternating between extremes of intense admiration and hatred of others.

☐ Have an unstable self-image or be unsure of his or her own identity.

☐ Act impulsively in ways that are self-damaging, such as extravagant spending, sex with many partners, substance abuse, binge eating, or reckless driving.

☐ Have recurring suicidal thoughts, make repeated suicide attempts, or cause self-injury through mutilation, such as cutting or burning oneself.

☐ Have frequent emotional overreactions or intense mood swings, including feeling depressed, irritable, or anxious. These mood swings may only last a few hours at a time. In rare cases, they may last a day or two.

☐ Have long-term feelings of emptiness.

☐ Have inappropriate, fierce anger or problems controlling anger – or often display temper tantrums or get into fights.

☐ Have temporary episodes of feeling suspicious of others without reason (paranoia) or losing a sense of reality.

MEDICATIONS – CURRENT and PAST MEDICATIONS

List ALL CURRENT MEDICATIONS, VITAMINS, HERBAL, & SUPPLEMENTS that you are now taking:

Medication, Vitamin, or Herbal	Medication, Vitamin, or Herbal	Medication, Vitamin, or Herbal

List ALL PAST MEDICATIONS that you have taken:

√ if Taking Now or Past	Medication Have you ***ever*** taken any of these:	dose	When & Why Stopped	When	√ if Taking Now or Past	Medication Have you *ever* taken any of these:	dose	When & Why Stopped	When
□Now □Past	**Ritalin/Methylin**				□Now □Past	**Abilify**			
□Now □Past	**Metadate**				□Now □Past	**Aristada or Maintena**			
□Now □Past	**Mydayis**				□Now □Past	**Rexulti**			
□Now □Past	**Aptensio**				□Now □Past	**Geodon**			
□Now □Past	**Concerta**				□Now □Past	**Risperdal/Invega**			
□Now □Past	**Focalin (or XR)**				□Now □Past	**Zyprexa**			
□Now □Past	**Daytrana**				□Now □Past	**Seroquel (or XR)**			
□Now □Past	**Adderall (or XR)**				□Now □Past	**Saphris**			
□Now □Past	**Vyvanse**				□Now □Past	**Fanapt**			
□Now □Past	**Other stimulant**				□Now □Past	**Latuda**			
□Now □Past	**Strattera**				□Now □Past	**Vraylar**			
□Now □Past	**Qelbree**				□Now □Past	**Caplyta**			
□Now □Past	**Clonidine**				□Now □Past	**Clozapine**			
□Now □Past	**Guanfacine**				□Now □Past	**Lithium**			
□Now □Past	**Prozac**				□Now □Past	**Depakote**			
□Now □Past	**Zoloft**				□Now □Past	**Tegretol** (Carbamazepine)			
□Now □Past	**Paxil**				□Now □Past	**Trileptal**			
□Now □Past	**Luvox**				□Now □Past	**Lamictal** (lamotrigine)			
□Now □Past	**Celexa**				□Now □Past	**Topamax**			
□Now □Past	**Lexapro**				□Now □Past	**Valium** (Diazepam)			
□Now □Past	**Effexor XR**				□Now □Past	**Xanax** (Alprazolam)			
□Now □Past	**Pristiq**				□Now □Past	**Ativan** (Lorazepam)			
□Now □Past	**Cymbalta**				□Now □Past	**Klonopin** (Clonazepam)			
□Now □Past	**Wellbutrin**				□Now □Past	**Lyrica**			
□Now □Past	**Remeron**				□Now □Past	**Neurontin**			
□Now □Past	**Buspirone**				□Now □Past	**Hydroxyzine**			
□Now □Past	**Trintellix**				□Now □Past	**Ambien (or CR)**			
□Now □Past	**Viibryd**				□Now □Past	**Lunesta**			
□Now □Past	**Fetzima**				□Now □Past	**Temazepam**			
□Now □Past	**Nefazodone**				□Now □Past	**Sonata**			
□Now □Past	**Amitriptyline**				□Now □Past	**Trazodone**			
□Now □Past	**Imipramine**				□Now □Past	**Rozerem**			
□Now □Past	**EMSAM**				□Now □Past	**Melatonin**			
□Now □Past	**Nardil**				□Now □Past	**Benadryl** (antihistamine)			
□Now □Past	**Parnate**				□Now □Past	**Other OTC sleep aid**			
□Now □Past	**Ketamine**				□Now □Past	**Buprenorphine**			
□Now □Past	**Provigil/Nuvigil**				□Now □Past	**Antabuse** (disulfiram)			
□Now □Past	**Aricept** (donepezil)				□Now □Past	**Campral** (acamprosate)			
□Now □Past	**Namenda** (memantine)				□Now □Past	**Naltrexone (oral or injectable)**			