GREATER LOWELLPSYCHIATRIC ASSOCIATES, LLC 73 PRINCETON STREET SUITE 203 NORTH CHELMSFORD, MA 01863

ADULT SELF-ASSESSMENT

Date:_______________ Form completed by:______________________________ Relationship to patient:______________

Referral Source:____ Tel #:____________________

Name of Patient:____ Sex: ☐M ☐F

Date of birth:_________________________ Age:________ Social Security #:____________________

Place of birth:______________ Primary Language:____________________ Occupation:______________

Home Phone: ______________ Work phone:____________________ Cell Phone:______________

Home address:____

City ______________ MA ______________ Zip Code ______________

Health Insurance:_____________________________________ Subscriber:______________

In case of emergency, notify:____________________________ Tel #:____________________

Relationship:____________________________ Is this person aware that you are receiving services at GLPA?

☐ Yes ☐ No

Please note that by providing us with this emergency contact's information, you are giving GLPA the right to contact this person at anytime if we have determined that the above patient is in an emergency situation.

PRESENTING ISSUES:

Please explain why you have chosen to seek counseling and/or medication evaluation at this time:

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Do any of the following currently apply to you?

√	Problem/Concern	√	Problem/Concern	√	Problem/Concern	√	Problem/Concern
	Depressed		Thoughts of Hurting Self		Phobic/Fearful		Losing Track of Time
	Low Energy		Thoughts of Hurting Others		Nauseated		Can't Stop Unpleasant Thoughts
	Low Self Esteem		Sadness/Grief		Fear of Losing My Mind		Angry/Frustrated
	Poor Concentration		Stress		Obsessive Thoughts		Easily Agitated/Annoyed
	Hopelessness		Anxiety/Panic		Compulsive Behaviors		Ignoring Rules
	Worthlessness		Heart Pounding/Racing		Racing Thoughts		Blaming Others
	Guilt		Chest Pain		Overspending		Frequently Arguing/Fighting
	Sleeping Less		Trembling/Shaking		Gambling		Using Drugs
	Sleeping More		Sweating		Delusions/Hallucinations		Using Alcohol
	Eating Less		Tingling/Numbness		Confusion		Blacking Out
	Eating More		Chills/Hot Flashes		Nothing Feels Real		Physically Sick all the Time
	Isolating/Withdrawal		Fear of Dying		Nightmares		Sexual Abuse
	Lonely		Relationship Problems		Family Problems		Physical Abuse
	Other Problems:						

How long have these issues existed? (# of weeks, months, years)____________________

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PATIENT NAME: ______________________________

Is there anything that you think may have led up to your current difficulties?______________________

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MEDICAL INFORMATION:

Primary Care Physician:______________________ Practice Name:______________________

Tel #:______________ Date of last physical:__________ Date of next appointment:__________

√	Symptom/Concern	For How Long?	Are You Receiving Treatment For This Problem? Explain:
	Frequent Or Severe Headaches		
	Dizziness / Vertigo		
	Convulsions or Seizures		
	Hypertension		
	Vision Problems		
	Hearing Problems		
	Smelling Or Taste Problems		
	Thyroid Problems		
	Persistent Cough		
	Chest Pain		
	Shortness of Breath / Asthma		
	Chronic Fatigue		
	Sleep Disturbance		
	Nausea / Vomiting / Diarrhea		
	Abdominal Pain		
	Constipation		
	Urinary Problems		
	Arthritis		
	Diabetes		
	Obesity		
	Walking / Movement Problems		
	Other:		

What illnesses or surgeries have you had in the past? ______________________

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Do you exercise? ☐ Yes ☐ No If yes, how much per week?__________ What do you do?__________

Do you smoke? ☐ Yes ☐ No How long have you smoked?______ How much do you smoke per day?________

How would you rate your health? ☐ Poor ☐ Fair ☐ Good ☐ Excellent

Please indicate your birth family's medical and psychiatric history below:

Health Issue	Birth Mother	Birth Mother's Family	Birth Father	Birth Father's Family	Siblings (who?)	Other Relatives (who?)
Allergies						
Asthma / Emphysema						
Diabetes						
Heart Condition						
Mental Retardation						
Seizure Disorder						
Depression						
Schizophrenia						
Other Psychiatric Illness						
Trauma / PTSD						
Learning Disability						
Behavioral Problems						
Alcohol Abuse						
Drug Abuse						
Other Illness (Explain)						

PATIENT NAME: ______________________

PSYCHIATRIC TREATMENT:

Are you currently receiving outpatient psychiatric services, please indicate services below:

√	Type if Psychiatric Service:	Name/Tel # of Clinician/Clinic	Starting Date:
	Medication Management		
	Individual Therapy		
	Group Therapy		
	Family Therapy		
	Day Treatment		
	Residential		
	Other:		

If you have previously seen a counselor or psychiatrist/prescriber before, please describe below:

Dates of Treatment	Name / Tel # of Clinician:	Describe Symptoms Treated:

If you have ever been hospitalized for psychiatric symptoms, please describe below:

Dates of Treatment	Name of Hospital	Describe Symptoms Treated:

Do you have a personal or family history of domestic violence, physical/emotional/sexual abuse or neglect? ☐ Yes ☐ No

Please explain: ____

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How you or your family received counseling or other services to address the above abuse o- neglect? ☐ Yes ☐ No

Please describe (include dates):____

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PATIENT NAME: ______________________