419 SW 15th Street
Ocala, FL 34471
Phone (352) 615-2226 Fax (727) 733-6002
www.ocalapsychiatry.com

Psychiatric History

Patient Name: _____ DOB_____

Reason for Visit:_____ Date:_____

Past Psychiatrist / Therapist:_____ Date Last Seen:_____

Past Psychiatric Diagnosis: _____

Past Psychiatric Medications: _____

_____

Have you ever been hospitalized for any psychiatric reasons? YES ○ NO ○

If yes, how many times? _____ Reason:_____ Hospital:_____ Date:_____

Have you ever been placed under a Baker Act? YES ○ NO ○

If yes, how many times?_____ Reason:_____ Hospital:_____ Date:_____

Have you ever attempted to commit suicide? YES ○ NO ○

If yes, how many times?_____ Method:_____ Date:_____

Do you have a history of substance abuse or alcohol abuse? YES ○ NO ○

If so, please explain:_____

_____

Medical History

Allergies: _____

Current Medical Issues: _____

Current Non-psychiatric Medications: _____

Surgical History: _____

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Social History

Smoking status (please circle one that applies): Current Smoker Former Smoker Never Smoke

Marital Status: Single Married Divorced Widow Separated Other

Employment Status: Employed Unemployed Disabled Retired

Employer Name: _____

Reason for Disability: _____

Living with: ◯ Alone ◯ Family ◯ Spouse

Sexual Orientation (optional): ◯ Heterosexual ◯ Homosexual ◯ Bisexual

Have you ever been treated for substance abuse? YES ◯ NO ◯

If so, please explain:_____

_____

Family History

11. Family Psychiatric History (please check all that apply & list family member):

- Depression – family member(s):_____
- Anxiety – family member(s):_____
- Bi-polar – family member(s):_____
- Schizophrenia – family member(s):_____
- Suicidal Attempts – family member(s):_____
- ADD/ADHD – family member(s):_____
- Alcoholism – family member(s):_____
- Drug abuse – family member(s):_____
- Dementia – family member(s):_____

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Please check all that apply:

- Depressed mood
- Hopeless or helpless
- Don't do pleasure or leisure activities like I use to
- Feelings of guilt
- Feelings of worthlessness
- Low self-esteem
- Decreased energy
- Decreased concentration
- Appetite or weight changes
- Moving slower or speaking slowly
- Feeling fidgety or have feeling of inner restlessness
- Sex drive changes
- Fatigued / tired most days
- Feel irritable often for no reason
- Harder to make decisions than I use to
- Sleep problems
  - Hard to get to sleep, but I stay asleep
  - Hard to stay asleep, but I get to sleep ok
  - Hard to get to sleep and hard to stay asleep
- Ideas of suicide or death
- Anxious
- Panic attacks
- Fear of social situations
- Obsessions
- Compulsions

- Do you feel threatened or scared?
- Are people out to get you?
- Can you read people's thoughts?
- Does the TV or Radio talk to you?
- Hear voices others cannot?
- See things others cannot?
- I have intrusive thoughts that are not my own
- I have special abilities or powers others do not have
- Thoughts are put inside my head by others
- I sometimes have out of body experiences
- Mood swings or irritability

- Anger outbursts
- Decreased need for sleep
- More talkative
- Racing thoughts
- At times, I become overly distracted where even small things pull me away from important things.
- At times, I do more risky things than usual or I spend money out of control or get involved in sex or other adventures that often turn out badly.
- At times, I am more Impulsive than usual and do things that are totally out of character for me.
- At times, I start many projects or get into so many activities that I cannot complete and I jump from one to another rapidly.
- At times, I am unusually irresponsible and take action that causes moderate to severe problems (legal, financial, relationship) for me and my family.

- I have experienced a traumatic event
- I often have the same nightmare or bad dream
- Memories come into my mind when I don't want them
- Sometimes I feel numb all over when I have some memories
- I avoid certain people and places I go
- Sometimes I feel so much fear that I detach myself or feel disassociation from people or places
- I am hyper-vigilant / hyper-aware even when no danger is present
- I have many body aches and pains
- I have neck, back and other chronic pain
- I have headaches / migraines often
- I have had a head injury in the past

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PHQ-9

Name_____ **Date** _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Please circle your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Total Score:_____

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Alcohol Misuse/Abuse Questionnaire
Audit-C

Name:_____ Gender:_____ Date:_____

Did you have a drink containing alcohol in the past year?

- Yes
- No

If Yes, : How often did you have a drink containing alcohol in the past year?

- Never (0 point)
- Monthy or less (1 point)
- 2 to 4 times a month (2 points)
- 2 to 3 times a week (3 points)
- 4 or more times a week (4 points)

How many drinks did you have on a typical day when you were drinking in the past year?

- 1 or 2 drinks (0 point)
- 3 or 4 drinks (1 point)
- 5 or 6 drinks (2 points)
- 7 to 9 drinks (3 points)
- 10 or more drinks (4 points)

How often did you have 6 or more drinks on one occasion in the past year?

- Never (0 point)
- Less than monthly (1 point)
- Monthly (2 points)
- Weekly (3 points)
- Daily or almost daily (4 points)

Points: