



7011 Ridge Road
Port Richey, FL 34668
Phone (727) 312-3883 Fax (727) 733-6002
www.portricheypsychiatry.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:

<ul style="list-style-type: none"><input type="checkbox"/> Depressed mood<input type="checkbox"/> Hopeless or helpless<input type="checkbox"/> Don't do pleasure or leisure activities like I use to<input type="checkbox"/> Feelings of guilt<input type="checkbox"/> Feelings of worthlessness<input type="checkbox"/> Low self-esteem<input type="checkbox"/> Decreased energy<input type="checkbox"/> Decreased concentration<input type="checkbox"/> Appetite or weight changes<input type="checkbox"/> Moving slower or speaking slowly<input type="checkbox"/> Feeling fidgety or have feeling of inner restlessness<input type="checkbox"/> Sex drive changes<input type="checkbox"/> Fatigued / tired most days<input type="checkbox"/> Feel irritable often for no reason<input type="checkbox"/> Harder to make decisions than I use to<input type="checkbox"/> Sleep problems<ul style="list-style-type: none"><input type="checkbox"/> Hard to get to sleep, but I stay asleep<input type="checkbox"/> Hard to stay asleep, but I get to sleep ok<input type="checkbox"/> Hard to get to sleep and hard to stay asleep<input type="checkbox"/> Ideas of suicide or death<input type="checkbox"/> Anxious<input type="checkbox"/> Panic attacks<input type="checkbox"/> Fear of social situations<input type="checkbox"/> Obsessions<input type="checkbox"/> Compulsions	<ul style="list-style-type: none"><input type="checkbox"/> I sometimes have out of body experiences<input type="checkbox"/> Mood swings or irritability<input type="checkbox"/> Anger outbursts<input type="checkbox"/> Decreased need for sleep<input type="checkbox"/> More talkative<input type="checkbox"/> Racing thoughts<input type="checkbox"/> At times, I become overly distracted where even small things pull me away from important things.<input type="checkbox"/> 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.<input type="checkbox"/> At times, I am more Impulsive than usual and do things that are totally out of character for me.<input type="checkbox"/> At times, I start many projects or get into so many activities that I cannot complete and I jump from one to another rapidly.<input type="checkbox"/> At times, I am unusually irresponsible and take action that causes moderate to severe problems (legal, financial, relationship) for me and my family.
<ul style="list-style-type: none"><input type="checkbox"/> Do you feel threatened or scared?<input type="checkbox"/> Are people out to get you?<input type="checkbox"/> Can you read people's thoughts?<input type="checkbox"/> Does the TV or Radio talk to you?<input type="checkbox"/> Hear voices others cannot?<input type="checkbox"/> See things others cannot?<input type="checkbox"/> I have intrusive thoughts that are not my own<input type="checkbox"/> I have special abilities or powers others do not have<input type="checkbox"/> Thoughts are put inside my head by others	<ul style="list-style-type: none"><input type="checkbox"/> I have experienced a traumatic event<input type="checkbox"/> I often have the same nightmare or bad dream<input type="checkbox"/> Memories come into my mind when I don't want them<input type="checkbox"/> Sometimes I feel numb all over when I have some memories<input type="checkbox"/> I avoid certain people and places I go<input type="checkbox"/> Sometimes I feel so much fear that I detach myself or feel disassociation from people or places<input type="checkbox"/> I am hyper-vigilant / hyper-aware even when no danger is present<input type="checkbox"/> I have many body aches and pains<input type="checkbox"/> I have neck, back and other chronic pain<input type="checkbox"/> I have headaches / migraines often<input type="checkbox"/> 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)
- Monthly 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:
