Alarus healthcare

Patient Name: _____

FAMILY HISTORY FORM

Date of Birth: _____

INSTRUCTIONS: Your doctor/therapist would like you to answer the following questions. This will help him or her to better understand your situation.

PSYCHOLOGICAL HISTORY

1. What problem(s) caused you to come for treatment? _____

   _____

   _____

   When did the problem begin? _____

   Has the problem been constant since its beginning? ☐ Yes ☐ No

   What is the worst symptom you've had? _____

   Is the problem ever absent? ☐ Yes ☐ No If so, when? _____

   Who made the decision to come to therapy? _____

2. Have there been any recent illnesses or deaths among your family or close friends? ☐ Yes ☐ No
3. Have there been any recent major losses among your family or close friends? ☐ Yes ☐ No
4. Have there been any recent crises or major changes in your life? ☐ Yes ☐ No
5. Have you ever experienced any emotional, physical or sexual abuse? ☐ Yes ☐ No
6. Have you ever intentionally hurt yourself or made a suicide attempt? ☐ Yes ☐ No
7. Have you ever taken medication for anxiety, depression, sleep or other emotional conditions? ☐ Yes ☐ No
8. Have you ever been in counseling before? ☐ Yes ☐ No

   If so, for what issues? _____

   When and where did you receive counseling? _____
9. Have you had any hospitalizations for emotional problems? ☐ Yes ☐ No
10. Please name any people or organizations that you believe provide help and support for you. _____

    _____

MEDICAL HISTORY

1. List any current medical conditions or disabilities: _____

   _____
2. Are you taking any medications? ☐ Yes ☐ No

   List current medications & dose: _____
3. List any past medical conditions (include any surgeries): _____

   _____
4. Name of your primary care physician: _____ Phone: _____

   Address of primary care physician: _____
5. Have you had a medical exam within the past year? ☐ Yes ☐ No

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SYMPTOM CHECKLIST

The following is a list of symptoms that have to do with various psychological problems. Please circle the number from zero to four that best describes how much this symptom or feeling bothers you. Use the following scale:

0 = Not at all 1 = A little bit 2 = Moderately 3 = Quite a bit 4 = Extremely

In the <u>past week</u>, how much were you bothered by:

		Not at All		Moderately		Extremely
1.	Feeling depressed, sad, blue, down, unhappy most of the time	0	1	2	3	4
2.	Feeling easily annoyed or irritated	0	1	2	3	4
3.	Feeling no interest in things or avoiding enjoyable activities, family, or friends	0	1	2	3	4
4.	Feeling tired all the time even with adequate sleep	0	1	2	3	4
5.	Trouble concentrating; can't stay focused on activities	0	1	2	3	4
6.	Feeling lonely even when you are with people	0	1	2	3	4
7.	Feeling hopeless about the future	0	1	2	3	4
8.	Significant increase or decrease in appetite or weight	0	1	2	3	4
9.	Sleeping problems: can't fall asleep, restless sleep, sleeping too much	0	1	2	3	4
10.	Thoughts of suicide: thinking "I wish I were dead," "life isn't worth living anymore"	0	1	2	3	4
11.	Suicide attempt: Intent or action to hurt or kill self with pills, weapons, cuts, etc.	0	1	2	3	4
12.	Racing thoughts, rapid speech, little or no need for sleep, impulsive traveling and/or spending money	0	1	2	3	4
13.	Doing things without thinking and often getting yourself into a jam	0	1	2	3	4
14.	Feeling so restless you could not sit still	0	1	2	3	4
15.	Feeling anxious: worrying excessively or worry about many things	0	1	2	3	4
16.	Feeling tense or keyed up	0	1	2	3	4
17.	Spells of terror or panic	0	1	2	3	4
18.	Fearful feelings of being humiliated in social situations	0	1	2	3	4
19.	Feeling uneasy in crowds or in open spaces	0	1	2	3	4
20.	Feeling afraid to travel on buses, subways, trains, or planes	0	1	2	3	4
21.	Feeling inferior to others	0	1	2	3	4
22.	Having to avoid certain things, places or activities because they frighten you	0	1	2	3	4
23.	Sudden re-experiencing of feelings, thoughts, images of a traumatic event	0	1	2	3	4
24.	Temper outbursts that you could not control	0	1	2	3	4
25.	Feeling "nothing" or numb, as if blocked as in taking a pain killer	0	1	2	3	4
26.	Recurrent thoughts, impulses, or images that are intrusive and troubling	0	1	2	3	4
27.	Excessive repeating of an activity that you couldn't resist even though it sometimes seems foolish (e.g., cleaning, washing hands, counting, etc)	0	1	2	3	4
28.	Feeling that you are watched or talked about by others	0	1	2	3	4
29.	Seeing or hearing things outside yourself that others tell you are not really there	0	1	2	3	4
30.	The idea that someone else can control your thoughts	0	1	2	3	4
31.	Feeling that most people cannot be trusted	0	1	2	3	4
32.	Persistent fears about health problems despite doctors finding nothing wrong	0	1	2	3	4
33.	Episodes of binge eating, purging/vomiting, or periods of not eating	0	1	2	3	4
34.	Feeling others are to blame for most of your troubles	0	1	2	3	4
35.	Having urges to break or smash things or injure someone	0	1	2	3	4
36.	Other:	0	1	2	3	4

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DRUG AND ALCOHOL USE

A. Please describe the drug and alcohol use of your family. Use the number which best describes how often each person uses each drug. For your children, please write in the name of child at top of each column.

0 = never; 1 = less than once a month; 2 = 1-4 days a month; 3 = almost daily; 4 = daily; 5 = used in past, not using now

SUBTANCE	SELF	PARTNER/SPOUSE	CHILD	CHILD	YOUR PARENTS
Caffeine					
Nicotine					
Beer/wine/liquor					
LSD					
Marijuana					
Inhalants					
Sedatives					
Amphetamines					
Cocaine/Crack					
Other (specify)					

B. Are you concerned about your drug or alcohol use? ☐ Yes ☐ No

C. Is someone who cares about you concerned about your use of drugs or alcohol? ☐ Yes ☐ No

D. Do you ever feel guilty about your use of drugs or alcohol? ☐ Yes ☐ No

E. Are you concerned about the alcohol or drug use of someone in your family? ☐ Yes ☐ No

F. Did you grow up in a home in which a parent abused drugs or alcohol? ☐ Yes ☐ No

G. Has anyone in your family been in treatment for drug or alcohol abuse? ☐ Yes ☐ No

List who and for what treatment: _____

FINANCIAL / LEGAL HISTORY

A. Do you have serious financial concerns? ☐ Yes ☐ No

B. Have you ever been arrested? ☐ Yes ☐ No

C. Have you ever been involved with Protective Services? ☐ Yes ☐ No

SCHOOL, MILITARY & WORK HISTORY

A. Are you currently enrolled in school? ☐ Yes ☐ No

B. What is your highest grade completed? _____

C. If you are in school, what field are you studying? _____

D. Have you served in the military? ☐ Yes ☐ No

If yes, which branch? _____ When? _____

E. Are you currently employed? ☐ Yes ☐ No

If yes, what is your occupation? _____

What is the length of time at your current job? _____

THANK YOU FOR COMPLETING THIS INFORMATION.