Coastal Counseling Associates
Initial History Form

Name_____ Date_____

Age_____ Date of Birth_____SSN_____

Address_____

City_____ State_____ ZIP_____

Patient's Telephone (H)_____ (W)_____

Cell Phone Telephone (H)_____ Email _____

Job Title_____

School Attending_____

Family Physician & Telephone_____

Pharmacy Name & Location_____

Who referred you for this evaluation_____

Briefly describe the reason for referral_____

_____

What specific questions would you like answered by this evaluation?

1. _____

2. _____

3. _____

THIS FORM HAS BEEN COMPLETED BY: Patient_____ Other_____
If not completed by the patient, please provide the following information:

Name_____ Relationship to patient_____

Address_____

Telephone (H)_____ (W)_____

Personal History

Marital History

Current marital status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated ☐ Living with someone

Years married to current spouse: _____years. Number of times married: ____times.

Spouse's Name_____ Spouse's DOB_____

Spouse's Occupation_____

Spouse's Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Education History

Highest grade or degree earned_____

How would you describe your usual performance: ☐ A & B ☐ B & C ☐ C & D ☐ D & F

What was your best subject(s)? _____ Weakest_____

Were you ever held back to repeat a grade? _____

Were you ever in any special class (es) or received special services_____

Occupational History

Current job title_____

Length of employment and responsibilities_____

Previous employment: 1. _____

2. _____

3. _____

At any time on a job, were you exposed to toxic, hazardous, noxious, or otherwise dangerous substances: ☐ Yes ☐ No

Military History

Branch: ☐ Army ☐ Navy ☐ Airforce ☐ Marines ☐ Coast Guard ☐ Other_____

Discharge rank_____ Type of discharge_____ Years of service_____

Military duties_____

Major events (injury, exposure to chemicals, combat)_____

Recreation

Briefly list the types of recreational activities you enjoy_____

_____

Adult Medical History

Check all that currently apply (√):

☐AIDS or HIV	☐Head Trauma	☐Multiple sclerosis
☐Allergies	☐Heart disease	☐Parkinson's disease
☐Arteriosclerosis	☐Huntington's disease	☐Polio
☐Arthritis	☐High Blood Pressure	☐Radiation therapy
☐Blood disorder	☐Kidney disease	☐Seizures
☐Brain disease or infection	☐Liver disease	☐Senility (Dementia)
☐Cancer or chemotherapy	☐Lung disease	☐Stroke or TIA
☐Diabetes	☐Malnutrition	☐Thyroid disease
☐Hazardous substance exposure	☐Meningitis	☐Venereal disease

Any other problems_____

Have you ever been or are you currently pregnant_____

If so, have you had any medical problems with your pregnancy or pregnancies_____

Date of your last medical check-up_____

Findings of the check-up_____

Drug Allergies_____

Describe any medical hospitalizations or surgeries:

1. _____
2. _____
3. _____

List any medications (include over-the-counter or alternative medications) and the dosages:

1. _____	6. _____
2. _____	7. _____
3. _____	8. _____
4. _____	9. _____
5. _____	10. _____

Psychiatric History

Have you had any prior ***Outpatient*** psychological, psychiatric, or neuro-psychological evaluations or treatment? ☐Yes ☐No

If yes, please complete this information:

1. Name of provider and degree_____

Address_____

_____

Telephone Number_____

Dates/Duration and reason for this evaluation_____

Findings of the evaluation_____

2. Name of provider and degree_____

Address_____

_____

Telephone Number_____

Dates/Duration and reason for this evaluation_____

Findings of the evaluation_____

Have you had any prior ***In-patient*** evaluations or treatment? ☐Yes ☐No

If yes, please complete this information:

1. Name of hospital and address_____

Dates/Duration and reason for this evaluation_____

Findings of the evaluation_____

2. Name of hospital and address_____

Dates/Duration and reason for this evaluation_____

Findings of the evaluation_____

3. Name of hospital and address_____

Dates/Duration and reason for this evaluation_____

Findings of the evaluation_____

Psychiatric Medication List

Please check off medications used at any time (√):

Antidepressants

- ☐ Amitriptyline (Elavil, Endep)
- ☐ Amoxapine (Asendin)
- ☐ Bupropion (Wellbutrin)
- ☐ Citalopram (Celexa)
- ☐ Clomipramine (Anafranil)
- ☐ Desipramine (Norpramin)
- ☐ Desvenlafaxine (Pristiq)
- ☐ Doxepin (Sinequan)
- ☐ Escitalopram (Lexapro)
- ☐ Duloxetine (Cymbalta)
- ☐ Fluoxetine (Prozac)
- ☐ Fluvoxamine (Luvox)
- ☐ Imipramine (Janimine, Tofranil)
- ☐ Levomilnacipran (Fetzima)
- ☐ Maprotiline (Ludiomil)
- ☐ Mirtazapine (Remeron)
- ☐ Nefazodone (Serzone)
- ☐ Nortriptyline (Aventyl, Pamelar)
- ☐ Paroxetine (Paxil – Paxil CR)
- ☐ Phenelzine (Nardil)
- ☐ Protriptyline (Vivactil)
- ☐ Sertraline (Zoloft)
- ☐ Tranylcypromine (Parnate)
- ☐ Trazodone (Desyrel)
- ☐ Trimipramine (Surmontil)
- ☐ Venlafaxine (Effexor)
- ☐ Venlafaxine XR (Effexor XR)
- ☐ Vilazodone (Viibryd)

Mood Stabilizers

- ☐ Asenapine (Saphris)
- ☐ Carbamazepine (Epitol, Tegretol)
- ☐ Clozapine (Clozaril)
- ☐ Gabapentin (Neurontin)
- ☐ Haloperidol (Haldol)
- ☐ Lamotrigine (Lamictal)
- ☐ Lithium (Eskalith, Lithobid, Lithonate, Lithotabs)
- ☐ Lurasidone (Latuda)
- ☐ Oxcarbazepine (Trileptal)
- ☐ Phenytoin (Dilantin)
- ☐ Risperdal
- ☐ Thioridazine (Mellaril)
- ☐ Topamax
- ☐ Valproic Acid (Depakene, Depakote)
- ☐ Zyprexa

Anxiolytics/Hypnotics

- ☐ Alprazolam (Xanax)
- ☐ Buspirone (Buspar)
- ☐ Chlordiazepoxide (Librium, Livritabs, Mitran)
- ☐ Clonazepam (Klonopin)
- ☐ Clorazepate (Cloraze Caps, Gen-XENE, Traxene)
- ☐ Diazepam (Valium, Valrelease, Zetran)
- ☐ Estazolam (ProSom)
- ☐ Flurazepam (Dalmane)
- ☐ Halazepam (Paxipam)
- ☐ Lorazepam (Ativan)
- ☐ Oxazepam (Serax)
- ☐ Praxepam (Centrax)
- ☐ Quazepam (Doral)
- ☐ Temazepam (Restoril)
- ☐ Zolpidem (Ambien)
- ☐ Chloral Hydrate (Noctec, Aquachloral Supprettes)

Stimulants

- ☐ Dextroamphetamine (Dexedrine)
- ☐ Dextroamphetamine + amphetamine (Adderall)
- ☐ Methamphetamine (Desoxyn)
- ☐ Methylphenidate (Ritalin, Concerta, Metadate)
- ☐ Pemoline (Cylert)
- ☐ Atomoxetine (Strattera)

Alternative Supplements

- ☐ St. John's Wort
- ☐ Flax Seed Oil
- ☐ SAM-e
- ☐ Ginkgo
- ☐ Primrose
- ☐ Kava
- ☐ Valerian Root
- ☐ Melatonin
- ☐ DHEA
- ☐ Yohimbine

Substance Use History

Alcohol

I started drinking regularly at age: ☐ less then 10 years old ☐ 10 – 15 ☐ 16 – 18 ☐ 19 – 21 ☐ over 21

I drink alcohol: ☐ rarely or never ☐ 1-2 days/week ☐ 3-5 days/week ☐ Daily

I used to drink but stopped (date)_____

Preferred type(s) of drinks_____

Usual number of drinks I have at a time_____

My last drink was: less than 24 hours ago ☐ 24 - 48 hours' ago ☐ Over 48 hour's ago ☐

Check all that apply:

☐ I can drink more than most people my age and size before I get drunk.

☐ I sometimes get into trouble (fights, legal difficulty, problems at work, conflicts with family, etc.) after drinking.

☐ I sometimes blackout after drinking.

☐ DUI.

☐ I have gone through drug or alcohol withdrawal.

☐ I have been in alcohol or drug treatment.

☐ There is a family history of drug or alcohol use. ☐ Father ☐ Mother ☐ Brother ☐ Sister ☐ Grandparents

Drugs

Please check all the drugs you are now using or have used in the past:

Amphetamines (inc. diet pills)	☐ presently using	☐ used in past	☐ dependency
Barbiturates (downers, etc.)	☐	☐	☐
Cocaine or Crack	☐	☐	☐
Hallucinogenics (LSD)	☐	☐	☐
Inhalants (glue, nitrous oxide)	☐	☐	☐
Marijuana	☐	☐	☐
Opiate narcotics (heroin)	☐	☐	☐
PCP (angel dust)	☐	☐	☐

Please list all other drugs_____

Early History

You were born: ☐ On time ☐ Prematurely ☐ Late Your weight at birth: ☐ Lb. ☐ Oz.

Were there any problems associated with your birth (e.g., oxygen deprivation, unusual birth position) ☐ Yes ☐ No

If yes, describe_____

Check all that applied to your mother while she was pregnant with you (√):

☐ Accident
☐ Alcohol use
☐ Cigarette smoking
☐ Drug use
☐ Hazardous material exposure
☐ Illness
☐ Poor nutrition
☐ Psychological problems

Other problems_____

List all the medications (prescribed or over-the-counter) your mother took while pregnant_____

_____

Rate your developmental progress as it has been reported to you by check one description for each area:

	Early	Average	Late
Walking	☐	☐	☐
Language	☐	☐	☐
Toilet training	☐	☐	☐
Overall development	☐	☐	☐

As a child, did you have any of these conditions? Please check all that apply (√).

☐ Attention problems
☐ Clumsiness
☐ Developmental delay
☐ Frequent ear infections
☐ Head injury
☐ Hearing problems
☐ Hyperactivity
☐ Learning disability
☐ Muscle tightness
☐ Muscle weakness
☐ Poison Exposure
☐ Speech problems
☐ Vision problems

Other_____

As a child, did you have any of these medical conditions? Please check all that apply (√).

☐ Allergies
☐ Asthma
☐ Brain infection
☐ Cancer
☐ Cerebral palsy
☐ Chicken pox
☐ Colds (excessive)
☐ Diabetes
☐ Encephalitis
☐ Epilepsy or Seizures
☐ Fevers (104°F or higher)
☐ Heart problems
☐ Immune system disease
☐ Kidney problems
☐ Lung disease
☐ Measles
☐ Meningitis
☐ Pneumonia
☐ Poisoning
☐ Polio
☐ Rheumatic fever
☐ Scarlet fever
☐ Tuberculosis
☐ Whooping cough

Did you ever require hospitalization? _____

Medications as a child: _____ Reason_____

_____ Reason_____

Family History

Mother

What is your mother's name (include maiden name)_____

Is she alive? ☐Yes ☐No Year of Birth _____

If no, age and year of death_____ Cause of death?_____

Mother's level of education & occupation_____

Does your mother have a known or suspected psychiatric condition? _____

Brief describe your mother's health history_____

Father

What is your father's name? _____

Is he alive? ☐Yes ☐No Year of Birth _____

If no, age and year of death_____ Cause of death?_____

Father's level of education & occupation_____

Does your father have a known or suspected psychiatric condition? _____

Brief describe your father's health history_____

Family

When you were born, what was your parents' age? Mother's age_____ Father's age _____

How many brothers and sisters do you have? Brothers_____ Sisters_____

Where are you in the birth order? _____

Are there any unusual problems (physical, academic, psychological) associated with any of your brothers or sisters? If yes please describe:_____

_____

Who raised you?

☐Biological parent(s) ☐Relatives ☐Foster parents
☐Biological parent & other person ☐Adoptive parents ☐Institutional setting

If there is any other aspect of the family that you would like to explain, please use the following space_____

_____

_____

Symptom List

Please check all that apply or that you have noticed and are a concern.

Symptoms: I first began to notice symptoms beginning at the age of _____

Symptoms:

- ☐ Depressed mood
- ☐ Lack of interest
- ☐ Lack of pleasure
- ☐ Hopelessness & Helplessness
- ☐ Excessive guilt
- ☐ Emptiness
- ☐ Low esteem
- ☐ Self critical
- ☐ Irritable
- ☐ Anger
- ☐ Mood swings
- ☐ Poor concentration
- ☐ Poor memory
- ☐ Circular thoughts
- ☐ Suicidal thoughts
- ☐ Suicidal plan
- ☐ Sleep disturbance
- ☐ Too much sleep
- ☐ Too little sleep
- ☐ Nightmares
- ☐ Early morning awakening
- ☐ Poor appetite
- ☐ Excessive eating
- ☐ Low energy
- ☐ Social withdrawal
- ☐ Seasonal cycles

Anxiety Symptoms

- ☐ Anxious mood
- ☐ Panic
- ☐ Dizzy
- ☐ Fear of going crazy
- ☐ Fear of no escape
- ☐ Short of breath
- ☐ Rapid heart rate
- ☐ Sense of floating
- ☐ Avoiding crowds
- ☐ House bound
- ☐ Muscle tension
- ☐ Excessive worry
- ☐ Headaches
- ☐ Bowel disturbance

Other Mood Symptoms

- ☐ Elated mood
- ☐ Expansive mood
- ☐ Racing thoughts
- ☐ Impulsive
- ☐ Risky behavior
- ☐ Spending money
- ☐ Little need for sleep
- ☐ PMS

ADHD Symptoms

- ☐ Distractible
- ☐ Fidgeting
- ☐ Easily frustrated
- ☐ Poor coordination
- ☐ Restless
- ☐ Impulsive
- ☐ Inattentive
- ☐ Sensitive
- ☐ Daydreams
- ☐ Sullen
- ☐ Destructive
- ☐ Steals
- ☐ Lies
- ☐ Explosive
- ☐ Isolative
- ☐ No sense of fair play

Other Symptoms not listed above _____

_____

_____

_____

_____ _____

Signature Date