Patient Self-Evaluation Form

Last Name _____ First _____ Middle _____ DOB ___/___/____

Address _____

City _____, CA Zip _____ Phone _____ ❑ home ❑ cell

Age _____ SSN _____-_____-_____

❑ Male ❑ Female Allergies? _____ ❑ No known allergies

Referred by _____ Are you currently seeing a therapist? ❑ Yes ❑ No

Have you ever been in therapy? If so, when and for how long? _____

Have you ever seen a psychiatrist? If so, when and for how long? _____

1. When it becomes necessary to contact you by phone, please list the number(s) you wish us to call. May we leave messages, such as lab results, appointments, or other medical information on an answering device, or with another person who answers the phone at the following number(s)?

_____ ❑ Yes ❑ No _____ ❑ Yes ❑ No

2. Please list the name and phone number of an emergency contact person not living with you.

Name _____ Phone Number _____

I experience the following:

- ❑ Sleeping too much *(_____ hours in 24 hours)*
- ❑ Sleeping too little *(_____ hours in 24 hours)*
- ❑ Trouble falling asleep
- ❑ Trouble staying asleep
- ❑ Feeling sad
- ❑ Feeling tearful
- ❑ Low energy
- ❑ Decreased memory
- ❑ Difficulty concentrating
- ❑ Low self-esteem
- ❑ I don't feel like doing things I used to enjoy
- ❑ Poor appetite
- ❑ Eating more than normal
- ❑ Weight gain
- ❑ Weight loss
- ❑ Feeling guilty
- ❑ Lower sex drive than normal
- ❑ Higher sex drive than normal
- ❑ Feeling violent
- ❑ Easily angered
- ❑ Feeling irritable
- ❑ Cutting or harming myself
- ❑ Suicidal thoughts
- ❑ Homicidal thoughts
- ❑ Feeling helpless
- ❑ Feeling hopeless
- ❑ Easily distracted
- ❑ Not needing sleep
- ❑ Feeling better than ever before
- ❑ Doing higher risk activities than normal, e.g., speeding, using drugs, gambling, indiscriminant sexual activities, etc.

  Please describe: _____

  _____
- ❑ Racing thoughts
- ❑ Talking faster than normal
- ❑ Feeling stressed
- ❑ Feeling easily overwhelmed
- ❑ Having more energy than normal

  Please describe: _____

  _____
- ❑ Feeling like I have special powers or ability

  Please describe: _____

  _____

Patient's Name _____ DOB _____

- ❑ Overindulging in something
  Please describe: _____
- ❑ Hearing voices no one else can hear
- ❑ Seeing things no one else can see
- ❑ Feeling like people are watching me, talking about me, plotting against me
  Please describe: _____
- ❑ Feeling panic in open areas
- ❑ Having panic attacks
- ❑ Feeling panic in closed areas
- ❑ Feeling overly frightened of something, e.g., spiders, elevators, etc.
  Please describe: _____
- ❑ Feeling panic for no apparent reason
- ❑ Having the same thoughts over and over; Obsessing over something
  Please describe: _____
- ❑ Having to do something over and over, e.g., checking if door is locked or stove is off, flipping light on and off, etc.
  Please describe: _____
- ❑ Feeling overly anxious or worried
- ❑ Doing something I consider a bad habit
  Please describe: _____
- ❑ Have you ever induced vomiting or used laxatives to control your weight or for any other reason?
- ❑ Are your symptoms worse in the winter? Or do they occur more in fall or spring?
  Please describe: _____
- ❑ Have you ever been diagnosed with a psychiatric illness? Please describe: _____
- ❑ Does anyone in your family suffer any psychiatric illness? Please explain:

- ❑ Do you use tobacco? How much and what form? _____
- ❑ Do you drink coffee, tea, or any stimulating drinks (e.g., Coca cola)? What kind, how much, and how often? _____
- ❑ Do you drink alcohol? What kind, how much, and how often? _____
- ❑ Do you use any recreational drugs, stimulants, or sedatives? Have you ever abused prescription drugs? If so, what kind, how much, and how often? _____

Would you like to state anything else you feel is important? _____

Who is your primary care doctor?

_____

Please list all **medical problems** and all **medications** you currently take, including **psychiatric medications**, over the counter medications, and any natural herbs.

Condition	Medication / Alternative Treatment

THE FOLLOWING QUESTIONS ARE FOR WOMEN ONLY.
(If you are male, please skip to the signature portion at the bottom of the page.)

Could you be pregnant? ❑ Yes ❑ No

Do you plan on getting pregnant? ❑ Yes ❑ No

Do you have a period? ❑ Yes ❑ No
If so, how often? _____

Are you regular? ❑ Yes ❑ No
Last menses: _____

If you no longer have a period, when did you reach menopause?
_____
Was it surgical or natural? _____

Are your symptoms related to your menstrual cycle? ❑ Yes ❑ No
If yes, please explain: _____
_____

Have any of your symptoms been related to your being pregnant?
If yes, please explain: _____
_____
_____

Do you currently have an OBGYN? ❑ Yes ❑ No

Do you take any form of hormonal treatment or contraception?
If yes, please explain: _____

THE INFORMATION I HAVE GIVEN ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

Patient's signature_____ Today's date _____

Patient's printed name _____