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Patient History and General Intake Form

Patient's Name: ____________________________Today's Date:___________________

Date of Birth: ______________________________Age:________

Gender: _____________________ Preferred Pronouns (e.g., he, she, they):_____________

Address:____

Home Phone:___________________ Office/Cell Phone: ____________________

Email is not considered secure enough for private health information but may be used for scheduling. If you'd like to use email to schedule appointments, please provide the best email address for you here: ____

Ethnicity: ________________________ Primary Language:_________________

Secondary Language: ____

Handedness: R___ L___ Both___ Years of schooling: ________________________

Who knows you well and is involved? (spouse, parent, child, other?)

Name: _______________________ Relationship: __________

Telephone number: (_____) ___________________

Referring physician: ______________________________ Phone: (_____) ______ -________

What would you like to learn from this evaluation? ___________________________________

____

____

Current diagnoses ____

Briefly describe the problems you have observed. ____________________________________

____

____

____

How long has this been going on?_______________

Has it progressed slowly or suddenly? (circle one)

List all current medical conditions: ____
____
____

Current Medication List (include vitamins, supplements, herbs):

Name of medication	Dosage	Frequency	prescribing MD	what is it for?

Use of medical or recreational marijuana? Yes________ No________

MRI date ________ MRI Results ____

EEG date ________ EEG Results ____

Any other tests? Labs results?____

Please ask your doctor to fax us any MRI reports, lab results, and/or clinical summaries of your condition to FAX: 415-627-9108. (Date requested ________________________)

Any difficulties with any of the following?

	None	**Mild**	**Moderate**	**Severe**	**Remarks**
Vision*					When evaluated:
Hearing*					When evaluated:
Smell/Taste					
Speech					
Dental					
Legs					
Arms					
Coordination					Falls?
Walking					
Sex					
Incontinence					

**** please bring any glasses or hearing aids to all appointments***

Any difficulties with any of the following?

	None	Mild	Moderate	Severe	How long has this been so?
Appetite					Weight loss/gain? Sweets?
Attention/Focus					
Language					
Memory					
Judgment					
Pain					Where?
Mood					

Any odd or problem behaviors? (Describe). Hallucinations? Delusions?
Misperceptions? Personality changes? Other?

____

____

Any change in social skills? ___________________________

Sleep: How many hours do you sleep per night on average? ______________________

Is this a change from a few years ago? _________

What time do you typically get to bed? _________ Fall asleep? ____________

Do you typically wake up in the middle of the night? ______

If so, how often or for how long? ___________________________

What time do you typically wake up and get up in the morning? _______________

Naps? _________ Time of day: __________ How long? __________

Nightmares? _________ Do you wake up feeling refreshed? _________ Do you snore? ________

Restless or painful legs at night? _________ Acting out your dreams? ________

Describe any difficulties with important responsibilities (cooking, paying bills, shopping, pill taking, making and keeping appointments, hobbies, organizations, etc.)

Have there been any difficulties with driving? ___(Describe accidents, tickets, getting lost, forgetting where you parked the car, etc.)

Who manages the finances? Since when?

Is there a DPOA (Durable Power of Attorney)? Who is it?

Describe any other changes you have noticed recently in your functioning.

Please describe your adult medical history including any major illnesses, surgeries, hospitalizations, seizure activity, blows to the head, loss of consciousness, etc.:

Do you have: Hypertension? _____ High cholesterol? _____ Anemia? _____

Thyroid disease? _____ Diabetes? _____ Vitamin deficiency? _____ Headaches? _____

Dizziness? _____ Constipation? _____ Stooped posture? _____ Staring spells? _____

Have you ever had: A stroke? Seizure? Loss of consciousness? Heart attack?

Please describe any use of drugs or tobacco. (When started, ended, how much, etc.).

How much alcohol do you drink these days?

C Have you ever felt you should *cut down* on your drinking?

A Have people *annoyed* you by criticizing your drinking?

G Have you ever felt bad or *guilty* about your drinking?

E *Eye opener:* Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover?

Have you ever been under the care of a psychiatrist, psychologist, or counselor? _______

If so, please describe what for: ____

Who treated you? ____

For how long? ____________ Did it help? _______________________________

Please describe your concerns or provide any additional information that you feel is relevant.

FAMILY HISTORY

Birthplace: ___________________________ If not Bay Area, when did you move here? ____

Who lives in the home? ____

If you are currently in a relationship, please provide the following information:

Partner's Name:_________________

Partner's Occupation:___________________

Relationship status (e.g., partnered, married)?_______________________

Length of relationship: _________________

Number of previous marriages: ________________

Mother's Education:______________Occupation? (even if retired) ______________________

Father's Education:_______________Occupation? (even if retired) ______________________

Siblings (names & ages, occupations): ____

____

Children (names & ages, occupations): ____

____

What languages are spoken in the home; which one is the primary language? ______________

Does anyone in the family (parents, siblings, cousins, etc) have any concerns similar to yours? If so, please describe:

What are the major medical conditions that run in the family? (Who?)

If your parents or siblings have passed away, what from?

Any family history of any neurological disease (epilepsy, memory disorder, etc)? (Who?)

Any family history of psychiatric disease (depression, anxiety, schizophrenia, etc)? (Who?)

Any family history of developmental disorder (intellectual disability, dyslexia, learning disabilities, etc.)? (Who?)

DEVELOPMENTAL HISTORY

Were you born (circle): on time premature How many weeks early? _____

How much did you weigh at birth? _______ Any complications at birth? ______________

Are you aware of any developmental delays (e.g., walking, talking)?
If so, describe:

Please describe your childhood medical history including any major illnesses, surgeries, hospitalizations, seizure activity, blows to the head, loss of consciousness, etc.:

EDUCATION AND WORK HISTORY

When did you start school? Age _____ Grade _____ Where? ____________________

Highest level of education _____________ Degrees and subjects ________________________

Were there any problems learning in school? _____ If yes, describe:

Did you receive speech therapy in school?_______ If yes, what ages?__________

Did you receive any special education or other pull-out services in school?______

What ages?________

Describe:

Were there any problems with behavior in school? _____ If yes, describe:

Describe your **academic skills** (e.g., grades, strengths/weaknesses). Best subject? Worst subject?

Please comment on your reading and writing ability. Has there been a change from previous years?

Any legal problems as a youth? _____ If yes, describe:

What kind of work do/did you do? ___________________ Where do you work? __________

How is your performance at work? ____

If retired, when did you retire? __________ And why? __________________________

Did you ever have a job with exposure to heavy metals? (lead paint, pesticides)?

Describe any **services** you receive:

How often per week?

PSYCHOSOCIAL HISTORY

Describe your **temperament/personality** (e.g., how you handle frustration)

How do you spend your days usually?

How do you spend your free time?

What do you enjoy doing? Hobbies/ past times?

How many days/week do you leave your home?　　　　How long?

Any legal problems as an adult? _____ If yes, describe:

Are there any legal concerns?　　　　Lawyer's name: ________________
Telephone: _______________

History of arrests?

What is your greatest stressor?

Any other concerns?

What are you most grateful for?

INSURANCE

Primary Insurance ___________________________ Number _______________

Secondary Insurance __________________________ Number _______________

I understand that I am responsible for ensuring that my insurance is active at the time of the evaluation and that, even if my insurance pre-authorizes the evaluation, it may not be covered. In such cases, payment for the evaluation is my full responsibility.

Signature ______________________________