



BENSON Health Clinic

Initial Psychiatric Evaluation Form

JILL LOY PMHNP-BC

First Name: _____

Last Name: _____

DOB: _____

Address: _____

E-Mail: _____

Phone: _____

Gender: (Please check one)

Female

Male

Transgender Female/Transwoman/MTF

Transgender Male/Transman/FTM

Gender Queer

Non-Binary

Additional Category **(Please specify)** _____

Decline to answer

What sex were you assigned at birth? (Please check one)

Female

Male

Other/Decline to answer _____

What pronouns do you prefer? (Check all that apply)

She/her/hers

He/him/his

They/them/theirs

Other: Please Specify: _____

Do you identify as: (Check all that apply)

Straight

Gay

Lesbian

Bisexual

Other: _____

Reason for seeking help?

Depression

Stress

Anxiety

Post-traumatic stress disorder (PTSD)

Bipolar disorder

Schizoaffective disorder

Schizophrenia

Personality disorder

Attention deficit hyperactivity disorder (ADHD)

Other: _____

Anxiety: Do you experience anxiety? (Check one)

Yes

No

Depression: Do you experience depression? (Check one)

Yes

No

Female: Are you pregnant? Or think you may be pregnant? (Check one):

Yes

No

Are you planning to become pregnant? (Check one)

Yes

No

Maybe

Birth Control Methods: _____

Most recent Mammogram: (Leave blank if you have not had one) _____

Last menstrual cycle: (Leave blank if you do not have one) _____

Current Providers/Doctors:

Psychiatric provider: (List name & phone number) _____

Previous Psychiatric provider(s): List name & phone number) _____

Therapist/Counselor: (List name & phone number) _____

Previous therapist/counselor (List name & phone number) _____

Mental Health Treatment Goals: What are your treatment goals? (Describe in your own words) : _____

Medical Information:

General Health(Check any/all that apply)
Recent changes in appetite
Weight gain/weight loss
Fevers
Chills/sweats
None of the above

Head (Check any/all that apply)
Occasional mild headaches
Migraines
Recent trauma/concussion
None of the above

Eyes(Check any/all that apply)
Recent visual changes/double vision
Presbyopia (Needs Bifocals)
Cataracts
Glaucoma
None of the above

Ears (check any/all that apply)
ringing
Infection
Drainage/pain
Mild hearing loss
Hearing Aid
None of the above

Nose/Throat/Mouth Check any/all that apply)
Frequent nose bleeds
Bleeding gums
Sores in mouth/lips
Difficulty swallowing
Hoarseness
None of the above

Lungs (Check any/all that apply)	
Wheezing	Chronic cough
Emphysema	COPD
Coughing up blood	TB
Positive skin test	Sleep Apnea
Use CPAP	Pulmonary Embolism
Asthma	None of the above

Heart (Check any/all that apply)	Heart Skips
Chest pain/Angina	Rapid heart rate
Exertional/nocturnal SOB	Cardiac testing within 1 Year
Heart Attack	Afib
Pacemaker	Mitral Valve Prolapse
Hypertension	None of the above

Breast (Check any/all that apply)
Current breast mass
Nipple discharge
Personal history of breast cancer
Breast augmentation
Current abnormal mammogram/sonogram
None of the above

Gastro-urinary (Check any/all that apply)	
Difficulty urinating	Difficulty holding urine
Frequent urination at night	Blood in urine
Kidney stones	Herpes
Prostate Cancer(Men Only)	Discharge for Penis (Men Only)
Menopause (Women Only)	Hysterectomy (Women Only)
Ovaries removed (Women Only)	None of the above

Musculoskeletal (Check any/all that apply)	Pain in Muscles
Pain in joints	Fibromyalgia
Muscle weakness	Chronic back problems
Arthritis under treatment	Varicose veins
Swollen ankles	None of the above

Neurological (Check any/all that apply)
Dizziness
Loss of consciousness
Transient loss of function
Stroke
Seizures
None of the above

Skin (Check any/all that apply)
Rash
Psoriasis
Non-healing lesions
History of skin cancers/melanoma
None of the above

Endocrine (Check any/all that apply)	Thyroid disorder
Masses	Heat/Cold intolerance
Taking thyroid medication	Diabetes under treatment
Excessive thirst/hunger/urination	Adrenal/pituitary disorder
None of the above	

	Hematologic (Check any/all that apply)		Anemia
	Bruise easily		Excessive bleeding
	Swollen glands		Leukemia
	Lymphoma		Transfusions
	Blood clots		Phlebitis
	Deep Venous Thrombosis(DVT)		Anticoagulated with Coumadin
	Sickle cell disease		None of the above

Medical History: Past medical problems, Non-psychiatric hospitalizations/surgeries:

Have you ever had an EKG? (Check one)

Yes When? _____ if abnormal, please describe _____

No

Date, doctor/provider, and place of last physical exam: _____

Have you ever been diagnosed with **Coronavirus (COVID-19)**

Yes if yes, When? _____ Were you hospitalized? Yes No

No

Have you had a COVID -19 Vaccine? (Check one)

Yes

No

	Self	Mother	Father	Paternal Grand Mother	Paternal Grand Father	Maternal Grand Mother	Maternal Grand Father
Thyroid disease							
Liver disease							
Asthma/Respiratory Disease							
Cancer							
Heart/Blood Pressure disease							
Liver problems							
Chronic Pain							
Anemia							
Kidney disease							
Diabetes							
Stomach/intestinal Problems							
Epilepsy/Seizures							
Head Trauma							
High Cholesterol							

Outpatient Psychiatric treatments

Age when first saw psychiatric/psychiatrist/therapist/counselor

Psychiatric Hospitalizations:

When? _____ Where? _____

Reason for hospitalization? _____

Past psychiatric medications:

If you have ever taken any psychiatric medication, please indicate the dates, dosage, and how helpful they were (if you can't remember all the details, just write in what you do remember)

Has anyone in your family been diagnosed with or treated for a psychiatric illness? (Please list)

Has any family member been treated with a psychiatric medication? (Please list who, what Medication (s) and how effective the treatment. If none, leave blank)

Substance Use:

Have you ever been treated for alcohol/drug use/abuse? (Check one)

Yes No

If Yes, for which substances?

When: _____ Where were you treated: _____

How many days per week do you drink alcohol? _____

How many alcoholic drinks do you have in one day? _____

Do you think you may have a problem with alcohol/drug use? Yes No

Have you ever used any street drugs in the past 3 months? Yes No

If yes, which ones? _____

Have you ever abused prescription medication? Yes No

If yes, which ones and for how long? _____

Do you use Marijuana products (THC, CBD, etc.)? __Yes __No

If yes, please list how much and how often: _____

Tobacco History(Check all that apply)	Yes, Currently	Not Currently	Never
Cigarettes			
Cigars			
Pipe			
Chewing Tobacco			

If yes, to any, how often per day on average? _____

If yes, to any how many years? _____

Family Background/Child Hood History:

Your developmental history: **(Check any/all that apply)**

No developmental delays

Pregnancy complications

Birth complications

Were you adopted? **(Check one)**

Yes

No

Where were you born? Where were you raised?

Please list your siblings and ages:

Did your parents' divorce (**Check one**)

Yes

No

If yes, who did you live with (**Check all that apply**)

	Full time	Mostly	Half & Half
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Are your parents living (**Check all that apply**)

Mother Yes No

Father Yes No

Legal History:

Briefly describe any past or current legal troubles:

Education (select highest degree COMPLETED)
Some High School
High School Graduate/GED
Some College
Associates degree
Bachelor's degree
Master's degree
Doctorate, PhD, MD

Occupation: (**List job title**)

Military History (Check one)

Yes, currently

Yes, Inactive/Discharged/Retired

No

Religion (Check one)

Yes

No

What religion: _____

Please describe your current relationship status (Check all that apply)	
<input type="checkbox"/> Single	<input type="checkbox"/> Married
<input type="checkbox"/> In a civil union	<input type="checkbox"/> In a domestic partnership/living together
<input type="checkbox"/> Partnered, not living together	<input type="checkbox"/> Divorced
<input type="checkbox"/> Widowed	<input type="checkbox"/> In committed relationship
<input type="checkbox"/> Separated	<input type="checkbox"/> Other

Living Situation

Who do you live with? _____

House

Apartment

Own

Rent

Support system) List anyone who you feels supports you in your life)
