BENSON Health Clinic

Initial Psychiatric Evaluation Form

MIRIAM THORNTON PMHNP

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						
	Father						
	Other						

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		
	Single		Married
	In a civil union		In a domestic partnership/living together
	Partnered, not living together		Divorced
	Widowed		In committed relationship
	Separated		Other

Living Situation

Who do you live with? _____

__House

__Apartment

__Own

__Rent

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

_____

Abuse/Trauma history (Check all that apply)

__History of physical abuse

__History of sexual abuse

__History of emotional abuse

__Other

Are you currently or have you ever been in a relationship where you were hurt, threatened, or made to feel afraid?

__Yes

__No

	Children		**How Many**		**Ages**	**Names**
	Biological					
	Adopted					
	Step					
	Other					

Allergies: List drugs, food, environmental agents, topical, supplement, herbs, animal allergies and reaction:

_____

_____

Current Medications:

List all current medications including Non-Prescriptions Drugs:

Current Medication	**Size/Dose**	**How do you take**