Alliance Health Medical History

Patient Information

Name: (First) (Middle) (Last) Date of Birth:

Please list any current medications, herbal supplements, and vitamins you take: ○ None
Please include dosage and how you were directed to take them.

1.)_____ 6.)_____ 10.)_____

2.)_____ 7.)_____ 11.)_____

3.)_____ 8.)_____ 12.)_____

4.)_____ 9.)_____ 13.)_____

5.)_____ 10.)_____ 14.)_____

List all allergies you have to medications, foods, and latex. Please include reaction you had when you were exposed. ○None

Past Medical History

Do you have or has a doctor told you that you had the following:

	Yes		Yes		Yes		Yes
Diabetes	○	Migraines	○	Depression	○	Narcolepsy	○
High blood pressure	○	Thyroid disease	○	Anxiety	○	Alcohol problems	○
High cholesterol	○	COPD/Emphysema	○	OCD	○	Drug abuse	○
Heart attack	○	Seizures	○	ADHD	○	Gambling problems	○
Congestive heart failure	○	Sleep apnea	○	bipolar	○	schizophrenia	○
Stroke	○	Bleeding disorders	○	Borderline	○	psychosis	○
Blood clots	○	Kidney disease	○			PTSD	○

Cancer ○ Which Type _____

Other medical problems you have, and serious illnesses in the past ○ none _____

Past psychiatric hospitalizations: Total # _____ Most Recent _____ Location _____
○ None

Past detox/rehab hospitalizations Total # _____ Most Recent _____ Location _____
○ None

Have you ever tried to end your life: (please circle) Yes No When was the most recent episode _____

Have you seen a psychiatrist before: (please circle) Yes No Name _____ how long ago _____

Are you currently seeing a therapist: (please circle) Yes No Name _____

Have you seen a therapist in the past: (please circle) Yes No Name _____ how long ago _____

Social History

Marital Status: (please circle) Single/ Married/ Separated/ Divorced/ Widowed How many children do you have _____(or circle) None
Work status: (please circle) Working Homemaker Paid leave Retired Disabled Student Unemployed
Most recent occupation: _____
Do you drink alcohol? No /Yes If yes, how many drinks (i.e. 12oz beer, 5oz glass of wine, 1.5oz of liquor) per week do you have:_____
Do you use any street drugs or substances? No /Yes If yes, explain:_____
Do you smoke or use tobacco? No /Yes If yes, how many packs/containers per day:_____
Has anyone **ever** kicked, slapped, hit, or punched you, physically abused you or verbally abused you? No /Yes_____
Legal issues: No /Yes, explain _____ OWI charges No /Yes Are you on Probation: No /Yes,

Family History

Do any of your siblings, parents, grandparents or children have any of the following (please mark Family member),

GP- grandparent
P- parent
S- Sibling
C- child (biological)

	GP	P	S	C		GP	P	S	C		GP	P	S	C
Diabetes	○	○	○	○	Depression	○	○	○	○	Narcolepsy	○	○	○	○
Heart disease	○	○	○	○	Anxiety	○	○	○	○	Alcohol problems	○	○	○	○
Heart attack	○	○	○	○	OCD	○	○	○	○	Drug abuse	○	○	○	○
Stroke	○	○	○	○	ADHD	○	○	○	○	Gambling problems	○	○	○	○
Kidney disease	○	○	○	○	Bipolar	○	○	○	○	Schizophrenia	○	○	○	○
Cancer	○	○	○	○	Borderline	○	○	○	○	Psychosis	○	○	○	○
										PTSD	○	○	○	○

May explain below:
_____

MEDICAL REVIEW OF SYSTEMS

Name:_____ Date _____

Since the last visit or within the last 3-4 weeks (Please check all that apply or mark none)

Constitutional: ☐ None
☐ fever ☐ chills ☐ excessive sweating ☐ weight gain ☐ weight loss ☐ sleep disturbance ☐ decreased energy
☐ Chronic pain ☐ easily fatigued ☐ recent trauma

Eyes, Ears, Nose, Throat: ☐ **None**

Ears: ☐ ear ringing ☐ change in hearing ☐ discharge from the ears ☐ deafness ☐ dizziness ☐ ear pain
Eyes: ☐ change in vision ☐ pain ☐ blurring ☐ tearing ☐ eyelid drop ☐ color change
Mouth and Throat: ☐ dental problems ☐ hoarseness ☐ difficulty swallowing ☐ gingival bleeding ☐ sore throat ☐ voice change
Neck: ☐ masses ☐ growth ☐ lymph node enlargement
Nose and Sinuses: ☐ discharge ☐ nose bleeds ☐ sinus pain ☐ congestion

Cardiovascular: ☐ **None**
☐ Chest Pain ☐ Palpitations ☐ Shortness of Breath at rest ☐ Lower extremity edema ☐ Dizziness ☐ Exercise Intolerance
☐ difficulty breathing, lying flat ☐ fainting spells ☐ Wounds-Ulcers in Feet--Slow to Heal

Chest/Respiratory: ☐ **None**
☐ Shortness of Breath ☐ Wheezing ☐ Cough ☐ coughing up blood ☐ Night Sweats ☐ Snoring
Breasts: ☐ pain ☐ lumps ☐ discharge from the nipple ☐ lumps or masses

Gastrointestinal: ☐ **None**
☐ Nausea ☐ Vomiting ☐ bloody stools ☐ Hemorrhoids ☐ Diarrhea ☐ Constipation ☐ Heartburn
☐ Change in Bowel Habits ☐ Abdominal Pain ☐ Cramping

Genitourinary: ☐ **None**
☐ pain with urination ☐ change in frequency of urination ☐ incontinence ☐ swelling ☐ retention
☐ blood in urine ☐ incomplete emptying ☐ hesitancy ☐ decreased force of stream
genital tract (male) ☐ pain or discomfort ☐ erectile dysfunction ☐ diminished orgasm ☐ diminished libido ☐ elevated libido
genital tract (female) ☐ pain or discomfort ☐ diminished orgasm ☐ diminished libido ☐ elevated libido

Musculoskeletal: ☐ **None**
☐ joint pain ☐ redness ☐ swelling ☐ limitation of function ☐ deformity ☐ back pain ☐ neck pain
☐ muscle pain ☐ joint stiffness ☐ decreased range of motion ☐ functional deficit ☐ arthritis

Skin: ☐ **None**
☐ discoloration ☐ bruising ☐ rash ☐ itching ☐ ulcers ☐ hair loss ☐ eczema ☐ excessive dryness

Neurological: ☐ **None**
☐ dizziness ☐ headache ☐ seizures ☐ smell changes ☐ difficult with balance ☐ difficulty in speaking ☐ seizures
☐ numbness ☐ tremor ☐ weakness ☐ change in speech ☐ tingling sensation ☐ changes in memory

Endocrinology: ☐ **None**
Hyperthyroid: ☐ heat intolerance ☐ sweaty ☐ diarrhea ☐ weight loss ☐ tremor ☐ palpitations ☐ visual disturbances;
Hypothyroid : ☐ cold intolerance ☐ slow ☐ tired ☐ thin hair ☐ croaky voice ☐ heavy periods ☐ constipation ☐ dry skin
Diabetes: ☐ increase urination ☐ constant hunger without weight ☐ sweaty ☐ tongue disarticulation
Adrenal: ☐ fainting spells ☐ darkening of skin in non-sun exposed places

Hematologic/Oncologic: ☐ **None**
☐ spontaneous or excessive bleeding ☐ fatigue ☐ enlarged or tender lymph nodes ☐ pale skin ☐ history of anemia
☐ abnormal bleeding ☐ skin bruising ☐ blood transfusions.

Allergies/Immunizations: ☐ **None**
☐ Difficulty breathing" or "choking as a result of exposure to anything ☐ Swelling or pain at groin ☐ itchy/teary eyes
☐ under arm or neck (swollen lymph nodes/glands) ☐ allergic response (rash/itch) ☐ unusual sneezing ☐ runny nose

Personal Health Questionnaire Depression Scale (PHQ-9)

Name: _____ Date: _____

Over the **last 2 weeks**, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not At all	Several Days	More Than half The days	Nearly Everyday
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping to much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself --- or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3
Add Colum		+	+	
Total:				

10. If you have experienced any of the problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____
Somewhat difficult _____
Very difficult _____
Extremely difficult _____

MOOD DISORDER QUESTIONNAIRE

Instructions: Please answer each question to the best of your ability.

	YES	NO
1. Has there ever been a period of time when you were not your usual self and...		
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	☐	☐
...you were so irritable that you shouted at people or started fights or arguments?	☐	☐
...you felt much more self-confident than usual?	☐	☐
...you got much less sleep than usual and found you didn't really miss it?	☐	☐
...you were much more talkative or spoke much faster than usual?	☐	☐
...thoughts raced through your head or you couldn't slow your mind down?	☐	☐
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	☐	☐
...you had much more energy than usual?	☐	☐
...you were much more active or did many more things than usual?	☐	☐
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	☐	☐
...you were much more interested in sex than usual?	☐	☐
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	☐	☐
...spending money got you or your family into trouble?	☐	☐
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	☐	☐

3. How much of a problem did any of these cause you – like being unable to work; having family, money or legal troubles; getting into arguments or fights? *Please circle one response only.*

No Problem Minor Problem Moderate Problem Serious Problem

4. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	☐	☐
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	☐	☐

Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

Patient Name		Today's Date	

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.

	Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?					
3. How often do you have problems remembering appointments or obligations?					
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?					

Part A

7. How often do you make careless mistakes when you have to work on a boring or difficult project?					
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
10. How often do you misplace or have difficulty finding things at home or at work?					
11. How often are you distracted by activity or noise around you?					
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?					
13. How often do you feel restless or fidgety?					
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?					
15. How often do you find yourself talking too much when you are in social situations?					
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?					
17. How often do you have difficulty waiting your turn in situations when turn taking is required?					
18. How often do you interrupt others when they are busy?					

Part B

(ZAN-BPD)

1. Have any of your closest relationships been troubled by a lot of arguments or repeated breakups? Yes____No____

2. Have you deliberately hurt yourself physically (e.g., punched yourself, cut yourself, burned yourself)? How about made a suicide attempt? Yes____No____

3. Have you had at least two other problems with impulsivity (e.g., eating binges and spending sprees, drinking too much and verbal outbursts)? Yes____No____

4. Have you been extremely moody? Yes____No____

5. Have you felt very angry a lot of the time? How about often acted in an angry or sarcastic manner? Yes____No____

6. Have you often been distrustful of other people? Yes____No____

7. Have you frequently felt unreal or as if things around you were unreal? Yes____No____

8. Have you chronically felt empty? Yes____No____

9. Have you often felt that you had no idea of who you are or that you have no identity? Yes____No____

10. Have you made desperate efforts to avoid feeling abandoned or being abandoned (e.g., repeatedly called someone to reassure yourself that he or she still cared, begged them not to leave you, clung to them physically)? Yes____No____