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SELF-ASSESSMENT FORM

Please Print

Name			**Date**
Street			**Suite/Apt. #**
City		**State**	**ZIP code**
Phone (home)		**Phone (work)**	
Age	**Date of Birth**		
Social Security Number		**Insurance**	

Name of person to call in an emergency			**Relationship**
Street			**Suite/Apt. #**
City		**State**	**ZIP code**
Phone (home)		**Phone (work)**	

Name of person filling out this form (if not patient)			
Name of referring clinician or primary care physician			
Street			**Suite/Apt. #**
City		**State**	**ZIP code**
Phone		**Date last seen**	

Check those that apply.

Race					
Caucasian	❑	African American	❑	Asian American	❑
Hispanic	❑	Native American	❑	Other	❑

Religion					
Protestant	❑	Catholic	❑	Jewish	❑
Muslim	❑	Hindu	❑	Other	❑

Residence					
house	❑	apartment	❑	room	❑
dormitory	❑	hotel	❑	hospital	❑
Other	❑				

Gender	Marital Status
Male ❑ Female ❑ Other ❑	never married ❑ living cooperatively ❑ married/partnered ❑ separated ❑ divorced ❑ widowed ❑

Occupation	If married, how many times?	If divorced, how many times?
	1 2 3 Other	1 2 3 Other

Education (please specify highest level completed)		
High school and earlier (circle highest grade): 6^{th} or earlier 7^{th} 8^{th} 9^{th} 10^{th} 11^{th} 12^{th} HS degree	College/University (years): 1 2 3 4/4+ BA/BS degree	Graduate/Professional School: MA/MS MBA JD MD PHD Other

Please state the principal reason you are requesting a consultation or treatment.

If necessary, use another sheet of paper.

Please describe your illness from the time of your first symptom to the present. Provide as many dates, names, and addresses of psychiatrists, psychologists, and/or social workers who have treated you as you can. Also, please provide the kinds of treatment you have received, including names of medications and your response to them.

If necessary, use another sheet of paper.

Suicide	
Check if you have ever thought about suicide.	❑
If "yes," when was the last time?	
Check if you have ever attempted suicide.	❑
If "yes," when and how?	
Check if you have thoughts about suicide now.	❑

Injury to Others	
Check if you have ever thought about hurting someone else.	❑
If "yes," when was the last time?	
Check if you have ever hurt someone else.	❑
If "yes," when and how?	
Check if you are thinking about hurting someone now.	❑

Recent Stressful Life Events **Check any of the following events that have occurred during the last 2 years.**	
married	❑
engaged	❑
separated	❑
divorced	❑
serious argument resulting in prolonged distress	❑
breakup of important relationship	❑
child left home	❑
death of spouse, other	❑
bad health (behavior) of family member	❑
difficulties with family member	❑
personal injury, illness	❑
sexual difficulties	❑
difficulties, changes at school or work	❑
retired, lost job	❑
changed residence	❑
legal difficulties, multiple traffic tickets	❑
owe considerable amounts of money	❑

Comments

Drinking (Alcohol Use)

How many drinks do you consume in the average day?	
At what time of day do you have your first drink?	
What is the most you have had to drink in a 24-hour period during the last year?	
Check if you ever felt that you were, or someone told you that you were, drinking too much?	❑
If "yes," under what circumstances?	

Drugs of Abuse

Check if you have taken any of the following drugs.

none	❑
marijuana	❑
amphetamines/speed	❑
heroin/opiates	❑
PCP	❑
LSD/hallucinogens	❑
cocaine/crack	❑
barbiturates/sedatives/downers	❑
mushrooms/psilocybin	❑
ketamine	❑
poppers/amyl nitrite/whipits/nitrous oxide/inhalants	❑
When did you most heavily use drugs?	
When was the last time you took such drugs?	

Personal History

Check any items that apply to you and explain.

Mother's pregnancy with you was abnormal	❑
Mother's delivery of you was abnormal	❑
Check if during childhood /adolescence you—	
were afraid to go to school	❑
had difficulty with reading, writing, or arithmetic/math	❑
were truant	❑
failed or repeated a grade	❑
had frequent falls	❑
were awkward at games	❑
wet bed after age 5	❑
had tics	❑
had trouble with eyes	❑
were(are) left handed	❑
mispronounced words, had a lisp, stutter/stammer	❑
had nightmares, disturbed sleep, fear of the dark	❑
ran away from home	❑
were cruel to animals	❑
often lied to family members or others	❑
set fires	❑
moved often	❑
were promiscuous	❑
were exposed to incest	❑
were physically/sexually/emotionally abused	❑

Comments

Family History			Major Illnesses
Name	Age[1]	Occupation[2]	List all major illnesses, including psychiatric, neurologic, alcoholism, drug abuse, suicide, and suicide attempts.
Mother			
Father			
Brothers			
Sisters			
Children			
Grandparents, uncles, and aunts (relationship)			

[1]Or if deceased, age at death. [2]Or if deceased, cause of death.

Medical History

Weight and Height

What is your current weight in pounds?	lbs.
Check if your weight has increased or decreased by more than 10 pounds during the last 5 years.	❑
If checked, explain circumstances.	
What is your height in inches?	in.

Sleep

Check if you—

have difficulty falling asleep	❑
have difficulty waking up and falling back to sleep	❑
are tired upon waking	❑
have bad dreams, wet bed, sleepwalk, or other sleep disturbances	❑

Smoking

Check if you smoke.	❑
If checked, how much and for how long?	

Caffeine

Check if you drink coffee, tea or colas.	❑
If checked, how much?	
Check if you believe you are sensitive to caffeine.	❑

Allergies

List all allergies. Be sure to include medication allergies.

Comments

Medical Problems	
Age when first occurred	List all past and present medical problems as well as any surgery or accidents.

Females–Menstrual History	
Check if your periods are irregular.	❑
If checked, explain.	
What is the duration of your periods?	
What is the date of your last period?	
Check if there is any pain or discomfort with your periods.	❑
Check if your moods, depression, irritability, and/or irrationality change with your periods.	❑
If checked, how?	
Check if you are taking an oral contraceptive.	❑
If checked, which one and for how long?	
If taking an oral contraceptive, check if it affects your mood.	❑

Comments

Current Medications and Dosages: