BNI Psychiatry

Adults Initial Evaluation

ID: _____

What is the main reason for your visit? _____

CC: _____

HPI: _____

When did it begin? _____

Psychiatric History
Outpatient Treatment

Have you ever had outpatient treatment for a psychiatric problem?
(please, circle) Yes No
If yes, what was the disorder? _____

When and where did you receive treatment? _____

What type of treatment was it (e.g., medication, counseling etc.)? _____

What was the name of your therapist/ psychiatrist? _____

Address: _____
Phone: _____

Do you authorize your BNI psychiatrist/ therapist to communicate with your therapist/ psychiatrist?
Yes No

PSH: _____

Hospitalizations
Have you ever been hospitalized for psychiatric reasons?
Yes No
If yes, please provide the dates, hospitals, and reasons:

Have you ever attempted suicide? Yes No

Patient's Signature _____ **Date:** _____

Medication History

What medications are you taking ***NOW*** (list all)?

Name	Dose	Name	Dose

Please list all the psychiatric medications you have tried:

(Example: citalopram, 02/98-05/98, good, poor sleep)

Name	Duration	Response	Reason for stopping

Do you use non-prescription medications or herbal medications? Yes No

If yes, which ones? _____

Do you or have you used recreational or illegal drugs ? Yes No

If yes, which drugs and how much? _____

Do you drink beverages with caffeine ? *(please, circle)*

Coffee Tea Sodas Others: _____

Cans/ Cups per day: _____

Do you drink alcohol? Yes No

On average week, how many days do you drink alcohol? ___

Do you smoke? Yes No

If yes, what and how much? _____

Do you exercise regularly? Yes No

SUD: _____

Patient's Signature _____ **Date:** _____

Medical History:

MEDH/O:

What illnesses or surgeries have you had in the past?

Do you have any illnesses at present? Yes No

If yes, please list:

Have you ever had a head injury? Yes No

If yes, when?

How did it occur?

Have you ever had an EEG, or CT or MRI scan of your head?

Yes No

If yes, when, and what were the results?

Name of your primary care physician:

Address:

Phone:

Do you authorize your BNI psychiatrist/ therapist to communicate with your primary care physician?

Yes No

Patient's Signature _____ **Date:** _____

Brief Review Of Systems:

Have you recently had any of the following?

Symptoms/ Problem	No	Yes	Date begun	
Frequent/severe headaches				
Dizziness/ vertigo				
Seizures/ /Convulsions				
Vision problems				
Hearing problems				
Smelling/ taste problems				
Thyroid problems				
Cough/ asthma				
Chest pain				
Shortness of breath				
Nausea/ vomiting/ /diarrhea				
Stomach pain				
Constipation				
Urinary problems				
Arthritis				
Diabetes				
Walking problems				
Cardiac pacemaker				
Vagal Nerve Stimulator (VNS)				
Other				

Patient's Signature _____ **Date:** _____

Family History

Looking at your family and all of your blood-relatives on both sides, do you think anyone has or had (list all that apply):

Illness	**Mother's side**	**Father's side**	**Siblings**
Depression			
Bipolar disorder			
Anxiety			
ADHD			
Schizophrenia			
Alcoholism			
Drug Abuse			
Learning disabilities			
Psychiatric hospitalization			
Suicide/ /Attempts			
Jail or Prison			
Mental Retardation			
Seizures			
Asthma			
Diabetes			
Thyroid disease			
Migraine			
Heart Problems			
Chromosomal disorders			
Other Problems (describe)			

Clinician's notes/ comments

Patient's Signature _____ **Date:** _____

Clinician's notes/ comments

Social History

Relationship status: single _____ married _____ (years)

in domestic partnership _____ (years)

widowed _____ (years)

divorced_____ (years)

Spouse's/ partner's occupation: _____

_____

SH: _____

Children

Name	Age	Location

Others currently living in your household and their relationship to you:

Name	**Relationship**

To be completed by your clinian:

MSE:

A

LOC: O: Memory: Attention:

Speech: TP: TC: AH/VH:

SI/HI: IC: Ins/Jud:

A/P:

AXISI:

AXISII:

AXISIII:

AXISIV:

AXISV:

1 6

2 7

3

4

5

Physician Sig:

date

Patient's Signature _____ **Date:** _____