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►►► Private and Confidential Medical Information ◄◄◄

Today's Date _____ Referred By _____

Patient's Name (Last, First, MI)_____

Birth Date ____ / ____ / _____ Age _____ Gender: M / F / other _____ SSN _____ - ____ - _____

Address _____ City _____ State _____ Zip _____

Phone numbers:	OK to leave messages?	Primary Contact Number?
Home: _____	☐ Yes ☐ No	☐
Cell: _____	☐ Yes ☐ No	☐
Work: _____	☐ Yes ☐ No	☐

Email: _____ May we use email to contact you? ☐ Yes ☐ No

**** Please note: email is not considered a confidential medium of communication ****

Primary Physician _____ Phone _____ Fax _____

Pharmacy _____ Phone _____ Fax _____

Therapist (if applicable) _____ Phone _____ Fax _____

Relationship Status:				
☐ Single		☐ Cohabitating / living together	# years _____
☐ Married	# years _____	☐ Partnered (same-sex marriage)	# years _____
☐ Divorced	# years _____	☐ Dispartnered (same-sex marriage)	# years _____
☐ Widowed	# years _____	☐ Separated	# years _____

Name of Spouse/Significant Other _____

May we contact your Spouse/Significant Other if we are unable to reach you? ☐ Yes ☐ No

If yes, please include Spouse/Significant Other's phone number _____

Initial _____

Names & Ages of Children _____

_____

Are you eligible for Medicare or receiving any disability compensation? ☐ Yes ☐ No

GENERAL MENTAL HEALTH INFORMATION

What are the problem(s) for which you are seeking help?

1._____

2._____

3._____

What are your treatment goals? _____

_____

_____

What significant life changes or stressful events have you experienced recently? _____

_____

What prompted you to seek treatment at this time? _____

Current Symptoms Checklist: (check once for any symptoms present, twice for major symptoms)

	Depressed mood		Racing thoughts		Excessive worry
	Loss of interest/enjoyment		Impulsivity		Anxiety / panic attacks
	Sleep pattern disturbance		Increased risk taking behavior		Avoidance
	Poor Concentration/forgetfulness		Decrease need for sleep		Hallucinations
	Change in appetite		Excessive energy		Suspiciousness
	Excessive guilt		Increased irritability		Unusual/Disturbing thoughts
	Fatigue / low energy		Increased sexual interest		Obsessive thoughts/ritual behavior
	Crying spells		Decreased sexual interest		Other

Past Psychiatric History:

History Outpatient treatment ☐ Yes ☐ No

Reason Dates Treated By Whom

_____

_____

_____

Initial _____

Psychiatric Hospitalization ☐ Yes ☐ No

Reason Date Hospitalized Where

_____

_____

_____

History of traumatic brain injury ☐ Yes ☐ No

_____

_____

Past Psychiatric Medications:

If you have ever taken any of the following medications, 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).

Medication	Dates	Dosage	Response/Side-Effects

Initial _____

Exercise Level:

Do you exercise regularly? ☐ Yes ☐ No

How many times per week do you generally exercise? _____

What types of exercise to you participate in? _____

Do you engage in any relaxation/mindfulness practices? ☐ Yoga ☐ Meditation ☐ Other _____

Family Psychiatric History:

Has anyone in your family been diagnosed with or treated for:

	No	Yes	If yes, who in your family had the condition?
Depression			
Anxiety			
Bipolar disorder			
Schizophrenia			
Post-traumatic stress			
Anger			
Violence			
Alcohol abuse			
Other substance abuse			
Suicide			
Other			

Has any family member been treated with a psychiatric medication? ☐ Yes ☐ No

Who was treated? What medication? How effective was the treatment?

_____

_____

_____

_____

_____

_____

_____

_____

Initial _____

Substance Use:

Check if you have ever tried the following substances:

	No	Yes	If yes, how long and when did you last use?
Methamphetamine			
Cocaine			
Stimulants (pills)			
Heroin			
LSD or Hallucinogens			
Marijuana / Cannabis			
Pain medication (not as prescribed)			
Methadone			
Tranquilizer/sleeping pills			
Alcohol			
Ecstasy			
Bath Salts			
Synthetic Marijuana (spice)			
Other			

Have you ever been treated for alcohol or drug use or abuse? ☐ No ☐ Yes - which substances? _____

_____

If yes, where and when were you treated? _____

_____

How many days per week do you drink any alcohol? _____

What is the most / least number of drinks you will drink in a day? _____

In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day? _____

Have you ever felt you ought to cut down on your drinking or drug use? ☐ Yes ☐ No

Have people annoyed you by criticizing your drinking or drug use? ☐ Yes ☐ No

Have you ever felt bad or guilty about your drinking or drug use? ☐ Yes ☐ No

Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? ☐ Yes ☐ No

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

Have you used any street drugs in the past 3 months? ☐ No ☐ Yes - which ones? _____

_____

Have you abused prescription medication? ☐ No ☐ Yes - which ones and for how long? _____

_____

Initial _____

Tobacco Use:

Do you smoke cigarettes? ☐ No ☐ Yes - Packs per day on average? _____ How many years?_____

In the past? ☐ No ☐ Yes - How many years did you smoke? _____ When did you quit? _____

Pipe, cigars, chewing tobacco, vape: Currently? ☐ Yes ☐ No. In the past? ☐ Yes ☐ No

What kind? _____How often per day on average? _____ How many years? _____

Suicide Risk Assessment

Have you ever had feelings or thoughts that you didn't want to live? ☐ Yes ☐ No
****If YES, please answer the following. If NO, please skip to Your Medical History ****

Do you currently feel that you don't want to live? ☐ Yes ☐ No

How often do you have these thoughts? _____

When was the last time you had thoughts of dying? _____

Has anything happened recently to make you feel this way? _____

_____

On a scale of 1 to 10, (ten being strongest) how strong is your desire to kill yourself currently? _____

Would anything make it better? _____

Have you ever thought about how you would kill yourself? _____

Is the method you would use readily available? _____

Have you planned a time for this? _____

Is there anything that would stop you from killing yourself? _____

Do you feel hopeless and /or worthless? _____

Have you ever tried to kill or harm yourself before? _____

Medical History:

Allergies_____ Current Weight _____ Height _____

How would you rate your physical health? (please circle) *Poor – Unsatisfactory – Satisfactory - Good - Very good*

Please list any specific health problems you are currently experiencing: _____

_____

How would you rate your sleeping habits? (please circle) *Poor – Unsatisfactory – Satisfactory - Good - Very good*

Please list any specific sleep problems you are currently experiencing: _____

Initial _____

Please list any difficulties you experience with your appetite or eating patterns. _____

_____

List ALL current prescription medications and how often you take them: (if none, write none)

Medication Name	Total Daily Dosage	Estimated Start Date

_____

_____

_____

_____

_____

_____

_____

_____

Current over-the-counter medications or supplements: _____

_____

Current medical problems: _____

_____

_____

Past medical problems, non-psychiatric hospitalization or surgeries: _____

_____

_____

Have you ever had an EKG? ☐ No ☐ Yes - when? _____ Was the EKG ☐ normal ☐ abnormal or ☐ unknown?

For women only:

Date of last menstrual period _____

Are you currently pregnant or do you think you might be pregnant? ☐ Yes ☐ No

Are you planning to get pregnant in the near future? ☐ Yes ☐ No

Birth control method _____

How many times have you been pregnant? _____ How many live births? _____

Personal and Family Medical History:

	You	Family	Which Family Member?
Thyroid Disease			
Anemia			
Kidney Disease			
Liver Disease			
Chronic Fatigue			
Diabetes			
Asthma/respiratory problems			
Stomach or intestinal problems			
Cancer (type)			
Fibromyalgia			
Heart Disease			
Epilepsy or seizures			
Chronic Pain			
High Cholesterol			
High blood pressure			
Head trauma			
Liver problems			
Other			

Do you have any concerns about your physical health that you would like to discuss with me? ☐ Yes ☐ No

Date and place of last physical exam:_____

Is there any additional personal or family medical history? ☐ No ☐ Yes - please explain _____

_____

When your mother was pregnant with you, were there any complications during the pregnancy or birth?

_____

Family Background and Childhood History:

Were you adopted? ☐ Yes ☐ No

Where did you grow up? _____

List your siblings and their ages: _____

_____

What was your father's occupation? _____

What was your mother's occupation? _____

Did your parents' divorce? ☐ Yes ☐ No - If so, how old were you when they divorced? _____

If your parents divorced, with whom did you live?_____

Describe your father and your relationship with him _____

_____

Describe your mother and your relationship with her _____

_____

How old were you when you left home? _____

Has anyone in your immediate family died? _____

Who and when? _____

Trauma History:

Do you have a history of being abused emotionally, sexually, physically or by neglect? ☐ Yes ☐ No.

If yes, describe when, where and by whom. _____

_____

Have you ever experienced a situation where your life was threatened or you witnessed harm to another person?

If yes, explain _____

Educational History:

Did you attend college? _____ Where? _____Major?_____

What is your highest educational level or degree attained?_____

Occupational History:

Are you currently: ☐ Working ☐ Not working by choice ☐ Unemployed ☐ Disabled ☐ Retired

How long in present position? _____

What is/was your occupation? _____

Where do you work?_____

Military History:

Have you ever served in the military? _____ If so, what branch and when? _____

Did you have an overseas deployment? ☐ No ☐ Yes – When and where? _____

Honorable discharge ☐ Yes ☐ No Other type discharge _____

Relationship History and Current Family:

Have you had any prior marriages? ☐ No ☐ Yes – list dates _____

Legal History:

Have you ever been arrested? ☐ No ☐ Yes - list dates _____

Do you have any pending legal problems? ☐ No ☐ Yes – Explain _____

Spiritual Life:

Do you belong to a particular religious or spiritual tradition? ☐ No ☐ Yes _____

What is your of your involvement? _____

During times when your condition is at its worst, do you find your involvement more helpful or does it make things more difficult or stressful for you? ☐ more helpful ☐ stressful – Please explain

_____

_____

Conclusion:

What do you consider to be some of your strengths?

_____

_____

_____

What do you consider to be some of your weakness?

_____

_____

_____

Is there anything else that you would like Dr. Leicken to know?

_____

_____

_____

_____

_____

Initial _____

Geriatrics Health History:
****This portion only needs to be completed by patients over the age of 60****

Please check any of the illnesses you have now or have had in the past and please indicate how much it interferes with your activities at present.

	Illness		Level of Impairment		
	Current	Past	None	Some	Significant
Arthritis					
Glaucoma / Cataracts					
Breathing Problems					
Asthma					
Bronchitis					
Emphysema					
High Blood Pressure					
Tuberculosis					
Diabetes					
Poor Circulation Arms/Legs					
Anemia					
Bleeding Problems					
Thyroid Problems					
Cancer or Leukemia					
Digestive Problems					
Ulcers					
Heartburn					
Hiatal Hernia					
Colitis					
Constipation					
Diverticulitis					
Seizures					
Parkinson's Disease					
Urinary Problems					
Wetness After Sneeze/Cough					
Urgency to Urinate					
Frequent Urination					
Burning on Urination					
Prostate Problems					
Difficulty Walking					
Dizziness					
Falling					
Broken Bones					
Weight Loss					
Unsteadiness					
Other					

Initial _____