Psychiatry
Helping You Find Answers

Self-Report Form

The information on this form will help us evaluate your needs and work with you to develop a treatment plan. This form will be included in your medical record. We hope that you will fill it out as completely as possible; however completion of all information is optional.

Name _____Date of Birth _____

Telephone (Home) _____(Work) _____

Home Address_____

City_____State_____Zip_____

Who referred you to our program? _____

Primary Cary Provider_____

Have you had previous mental health treatment before? _____

If yes, with who &when _____

Have you had any previous mental health hospitalizations? #_____

Your Concern/s

Please describe the problem(s) or the concerns that brought you here today.

When did these problems begin?

Please give examples of the problem(s).

Please describe your strengths.

What feelings do you MOST OFTEN show when faced with stress or other problems (i.e., anger, fear, sadness, etc.)?

What seems to help you to deal with stress or problems?

What seems to make things worse?

Birth and Early Development History

Were there any complications with your mother's pregnancy with you or your birth ___
If yes please explain_____

Were there any concerns with your early and childhood development ___
If yes please explain_____

Infancy

Yes	No	Enjoyed cuddling	Yes	No	Fussy, irritable
Yes	No	More active than other babies	Yes	No	Sleeping difficulties
Yes	No	Colic	Yes	No	Feeding difficulties

Developmental History

Compared with other children please check the times for your:

Crawling		Early	Normal	Late
Walking		Early	Normal	Late
Language development		Early	Normal	Late
Toilet training		Early	Normal	Late
Writing skills		Early	Normal	Late
Bladder trained, night		Early	Normal	Late
Rode bicycle		Early	Normal	Late

Medical History

Yes	No	Ear infections	Describe	
Yes	No	Ear tubes placed	Describe	
Yes	No	Vision problems	Describe	
Yes	No	Headaches	Describe	
Yes	No	Seizures	Describe	
Yes	No	Fainting	Describe	
Yes	No	Meningitis	Describe	
Yes	No	Asthma	Describe	
Yes	No	Pneumonia	Describe	
Yes	No	Heart problems	Describe	
Yes	No	Anemia	Describe	
Yes	No	Elevated lead levels	Describe	
Yes	No	Slow/fast weight gain	Describe	
Yes	No	Stomachaches	Describe	
Yes	No	Feeding difficulties	Describe	
Yes	No	Sleeping difficulties	Describe	
Yes	No	Kidney/ urinary problems	Describe	
Yes	No	Constipation / diarrhea	Describe	
Yes	No	Accidents	Describe	

Yes	No	Coordination problems	Describe	
Yes	No	Head injuries	Describe	
Yes	No	Hospitalizations	Describe	
Yes	No	Operations	Describe	
Yes	No	Other medical procedures	Describe	
Yes	No	Allergies	Describe	
Yes	No	Drug use	Describe	
Yes	No	Alcohol use	Describe	
Yes	No	Other health problems	Describe	

Females Only

Type of Birth Control (if applicable) and specify type, name, and dose (if pills):_____

Do you have regular periods? _____ Date of last period_____

Are you pregnant? __YES __NO

Are you breast-feeding? __YES __ NO

Medications

Do you have any allergies? Yes ___ No ___

If yes, what:

_____

Current Medications and supplements

Medication name	Strength	How often

Family History

Family Outline

Who lives in your home?				
Do you have children?				
Do you have brothers or sisters?				
What is your home's primary language?				
	English	Spanish	Other _____	
Check all of the following the following that apply:				
Single, never married	Single but living with someone		Married, living together	
Married, living apart	Married, legally separated		Divorced	
Gay/ Lesbian single	Gay / Lesbian partners		Widowed	
Living alone	Other, specify _____			

Which of the following best describes your current living situation?

Rent apartment	Rent house	Own single / multiple family home
Subsidized housing	Condominium	Shelter
Homeless	Boarding school	Residential treatment
Group home	Other, specify _____	

Family Illness History

Please list all relatives on either side of the family who have had any of the following. Please indicate whether mother's or father's side of the family.

	Relationship to you	Mother's side	Father's side
Behavior problems			
Problems with attention			
Drug or alcohol abuse			
Problems with depression			
Problems with anxiety			
Psychiatric treatment			
Hospitalized psychiatrically			
Psychiatric medications			
Suicide ideas or attempts			
Trouble with the law			
Learning / Speech problems			
Mental retardation			
Migraine headaches			
Childhood diabetes			
Asthma			
Colitis			
Lupus erythematosis			

Arthritis			
Thyroid disease			
Seizures or epilepsy			
Tics and/or Tourette's syndrome			
Sudden or unexpected deaths			
Heart attack			
Coronary Artery Disease			
Cancer			
Diabetes Mellitus			
Hypertension			
Kidney disease			
Stroke			

Please mark if any of the following events have happened to you in the past TWO YEARS?

Yes	No	Moving to a new home		Yes	No	New child in home
Yes	No	Change in schooling/education		Yes	No	Child leaving home
Yes	No	Divorce		Yes	No	Fighting with partner
Yes	No	Lost job		Yes	No	Death of a family member
Yes	No	Separation		Yes	No	Death of a close friend
Yes	No	Increased absence of partner		Yes	No	Change in financial state
Yes	No	Serious illness of a family/friend		Yes	No	New member of household
Yes	No	New job		Yes	No	Pregnancy in home
Yes	No	Family/friend going to jail		Yes	No	Change in health
Yes	No	Trouble with family member		Yes	No	Major personal injury/illness
Yes	No	New significant other		Yes	No	Getting a new pet
Yes	No	Legal problems		Yes	No	Loss of a pet
Yes	No	Trouble with boss		Yes	No	Trouble with coworkers

Social History

PERSONAL HABITS:

Have you ever smoked? Yes ___ No ___ Do you currently smoke? Yes ___ No ___

Check if you regularly drink:

Hard liquor: 1-3oz per day ___ Over 3oz per day ___

Beer: 1bottle per day___ 2 bottles a day___ 3 or more a day___

Have you ever used any of the following?

Marijuana:___ LSD:___ Heroin:___ Cocaine:___ Speed:___ Other:___

If so, are you currently using? Yes___ No ___ If yes, what are you using:_____

School

Highest Grade completed_____

Attendance	Good	Average	Poor			
Quality of work	Good	Average	Poor			
Math ability	Good	Average	Poor			
Reading ability	Good	Average	Poor			
Homework behavior	Good	Average	Poor			
In School behavior	Good	Average	Poor			
Friendships	Good	Average	Poor			

Were you ever retained in a grade? Yes No If yes, which grade? _____

Special education, tutor, Core evaluation, IEP, etc. Yes No

If yes, please describe _____

Did you participate in sports or other activities? Yes No

Did you have medical and/or emotional issues that interfered with participation in school? Yes/ No

If yes, how?

Work

Occupation:_____ Are you retired? Yes ___ No ___

When_____ Are you disabled? Yes_____No____When_____

If you are employed outside the home:

	Current			Past Year		
Attendance	Good	Average	Poor	Good	Average	Poor
Quality of work	Good	Average	Poor	Good	Average	Poor
Relationship with supervisor	Good	Average	Poor	Good	Average	Poor
Relationship with coworkers	Good	Average	Poor	Good	Average	Poor
Motivation	Good	Average	Poor	Good	Average	Poor
Work behavior	Good	Average	Poor	Good	Average	Poor
Friendships	Good	Average	Poor	Good	Average	Poor

Approximately how many days have you missed this year? _____

About how many days did you miss last year? _____

Have you been reprimanded at work? Yes No

How long have you worked at our current job? _____ At your previous job?_____

Does your medical and/or emotional situation interfere with participation in work? Yes No

If yes, then how? _____

What does your work understand about your medical or emotional situation?

Community

In what community groups/activities do you participate? (School, clubs, church, support …)

_____

How often do you participate? _____

Who supports you emotionally? (Family, friends, groups, church…) _____

What prevents you from participating in things you would like to? _____

Activities and interests

Sports	little or no interest	moderate interest	strong interest
Outdoors	little or no interest	moderate interest	strong interest
Crafts	little or no interest	moderate interest	strong interest
Art	little or no interest	moderate interest	strong interest
Music	little or no interest	moderate interest	strong interest
Technology	little or no interest	moderate interest	strong interest
Clubs	little or no interest	moderate interest	strong interest
Fitness	little or no interest	moderate interest	strong interest
Spirituality	little or no interest	moderate interest	strong interest
Reading/writing	little or no interest	moderate interest	strong interest
Pets	little or no interest	moderate interest	strong interest

Current Symptoms

In the past months, please circle the 2 if the item is very true or often true. Circle the 1 if the item is somewhat or sometimes true. If the item is not true, circle the 0. Please answer all items as well as you can, even if some do not seem to apply.

0 = Not True (as far as you know) **1 = Somewhat or Sometimes True** **2= Very True or Often True**

0	**1**	**2**	• Feeling down/sad/empty	**0**	**1**	**2**	• Lacking energy / Fatigued
0	**1**	**2**	• Loss of interest & pleasure	**0**	**1**	**2**	• Feeling worthless / guilty
0	**1**	**2**	• Weight loss/gain; Appetite up/down	**0**	**1**	**2**	• Poor concentration, indecisiveness
0	**1**	**2**	• Insomnia or Sleeping too much	**0**	**1**	**2**	• Recurrent thoughts of death
0	**1**	**2**	• Feeling restless / Being slowed down	**0**	**1**	**2**	• Feeling ecstatic for no reason
0	**1**	**2**	• Grandiose/very high self-esteem	**0**	**1**	**2**	• Feeling irritable / easily angered
0	**1**	**2**	• Feeling rested with < 3 hrs. of sleep	**0**	**1**	**2**	• Thoughts going too fast
0	**1**	**2**	• Talking too much, too loud, too fast	**0**	**1**	**2**	• Being distracted
0	**1**	**2**	• Excessive and reckless indulgence	**0**	**1**	**2**	• Doing too much at the same time
0	**1**	**2**	• Fail to pay attention, Carelessness	**0**	**1**	**2**	• Can't concentrate
0	**1**	**2**	• Disorganized in tasks / activities	**0**	**1**	**2**	• Don't listen
0	**1**	**2**	• Avoid mentally challenging tasks	**0**	**1**	**2**	• Don't finish things
0	**1**	**2**	• Restless, fidgety, squirm in seat	**0**	**1**	**2**	• Often lose things
0	**1**	**2**	• Can't stay seated when required	**0**	**1**	**2**	• Easily distracted
0	**1**	**2**	• Lose temper often, Anger problem	**0**	**1**	**2**	• Often forgetful
0	**1**	**2**	• Argue with Authority figures	**0**	**1**	**2**	• Interrupt or intrude others
0	**1**	**2**	• Feel worthless or inferior	**0**	**1**	**2**	• Defy rules or request
0	**1**	**2**	• Annoy people on purpose	**0**	**1**	**2**	• Often angry and resentful
0	**1**	**2**	• Fear of losing control or going crazy	**0**	**1**	**2**	• Easily annoyed by others
0	**1**	**2**	• Would rather be alone than with others	**0**	**1**	**2**	• Skipping work
0	**1**	**2**	• Paranoid, feel like being followed/watched	**0**	**1**	**2**	• Thoughts about harming self or

							others
0	**1**	**2**	• Nervous, high-strung, or tense	**0**	**1**	**2**	• Unhappy, sad, or depressed
0	**1**	**2**	• Intrusive thoughts / flash - backs of trauma	**0**	**1**	**2**	• Unusually loud
0	**1**	**2**	• Feels dizzy	**0**	**1**	**2**	• Uses alcohol and/or drugs to excess
0	**1**	**2**	• Feels too guilty	**0**	**1**	**2**	• Nightmares about trauma, poor sleep
0	**1**	**2**	• Repetitive mental acts (counting, etc.)	**0**	**1**	**2**	• Withdrawn, doesn't get involved with others
0	**1**	**2**	• Physical problems without known medical cause	**0**	**1**	**2**	• Worries
0	**1**	**2**	• Aches or pains	**0**	**1**	**2**	• Is playful or lighthearted
0	**1**	**2**	• Headaches	**0**	**1**	**2**	• Has a good sense of humor
0	**1**	**2**	• Nausea	**0**	**1**	**2**	• Being vigilant / easily startled
0	**1**	**2**	• Problems with eyes	**0**	**1**	**2**	• Overtired
0	**1**	**2**	• Rashes or other skin problems	**0**	**1**	**2**	• Gets along with others
0	**1**	**2**	• Stomachaches or cramps	**0**	**1**	**2**	• Is independent
0	**1**	**2**	• Vomiting	**0**	**1**	**2**	• Likes to stay active
0	**1**	**2**	• Self-injuries behaviors (cutting, other)	**0**	**1**	**2**	• Has a positive outlook
0	**1**	**2**	• Chest pain, discomfort	**0**	**1**	**2**	• Is good dealing with daily problems
0	**1**	**2**	• Trembling, shaking	**0**	**1**	**2**	• Is easygoing or "laid back"
0	**1**	**2**	• Feeling unreal / detached from self	**0**	**1**	**2**	• Deals with change well
0	**1**	**2**	• Seeing things that others can not	**0**	**1**	**2**	• Hearing voices that others can not

Overview

What do you hope to gain from this evaluation?

Is there anything else you want your clinician to know about you or your situation?

_____ _____

Signature of person filling out this form Date

FOR OFFICE USE: Self-Report Form has been reviewed by the following clinician:
Signed _____ Date
_____
Print Name _____

Notes: