Insight Medical Group LLC

Health History Form

Name: _____ **Date of Birth**:_____/_____/_____

Reason for today's visit: _____

CURRENT MEDICATIONS

Name of Medication	**Strength** (ex. 500 mg)	**Dosing Instructions** (ex. Twice a day)

ALLERGY HISTORY

☐ No Known Allergies ☐ Medication Allergies ☐ Environmental/Seasonal Allergies ☐ Latex Allergies

Allergen (ex. Food, Dust, Animals, Pollen, Medication)	**Reaction** (ex. Rash, nausea, respiratory, shock, etc.)

SOCIAL HISTORY *(Please circle all applicable responses)*

Marital Status	Single Significant Other Married Divorced Widowed	
Sexual Orientation	Heterosexual Gay Lesbian Bisexual Transgender non binary	
Living Situation	Alone Spouse/Significant other Children/Family Homeless Residential Other:	
Females- Are you pregnant?	Yes / No Hysterectomy Menopause Tubal ligation	
What are your hobbies?		
Education (highest level)	9 10 11 12 Some college Associates Bachelors GED Masters PhD	
Employment?	Full-time Part-time Unemployed Seeking employment Disabled Retired	
If yes, Employer:	Occupation: # of Years:	
Previous work experience?	Yes / No	If yes, description:
Military History	None / Past / Current	Army Navy Marines Coast Guard National Guard
Combat?	Yes / No	If yes, Where:
Discharge?	Yes / No	If yes: Honorable General Dishonorable Retired Other
VA Disability?	Yes / No	If yes, due to:
Spiritual/ Religious Affiliation?	Yes / No	Practicing/ Role of Faith Past & Present?
Receiving Benefits?	Yes / No	APTD SSI SSDI Food Stamps Fuel Asst. Section 8 Disability Public/HUD Housing PASS Plan Workers comp Unemployment

			If applicable, amount?
Tobacco Use? *If no, have you ever?*	Yes / No Yes / No	Cigarettes / Cigars / Chew Cigarettes / Cigars / Chew	Per day: Per day:
Do you drink alcohol?	Yes / No	Beer / Wine / Liquor	Per day:
Do you drink caffeine?	Yes / No	Coffee / Tea / Soda / Energy Drink	Per day:
Do you exercise?	Yes / No	Type?	
Do you wear your seatbelt?	Yes / No	If yes, percent of time	

MEDICAL HISTORY *(Please check any of the following that you have or have had in the past)*

☐ Acid Reflux/GERD	☐ Cancer	☐ Headaches	☐ Liver Disease
☐ ADHD	☐ Chronic Cough	☐ Hearing Loss	☐ Osteoporosis
☐ Alcoholism	☐ Chronic Pain	☐ Heart Disease	☐ Seizure Disorder
☐ Anemia	☐ COPD/Emphysema	☐ Hepatitis	☐ Sexually Transmitted Disease
☐ Anxiety	☐ Dementia	☐ High Blood Pressure	☐ Stroke
☐ Arthritis	☐ Depression	☐ High Cholesterol	☐ Thyroid Disease
☐ Asthma	☐ Diabetes	☐ HIV/AIDS	☐ Tuberculosis
☐ Bleeding Disorders	☐ Eating Disorder	☐ Kidney Disease	☐ Other: _____
☐ Bowel Problems	☐ Glaucoma/Cataracts	☐ Immune Disorders	

- Are you/do you have: Obsessive compulsive? _____ Eating disorder? _____ Panic Attacks?_____
- Have you participated in high-risk sexual practices?_____ If so, please describe: _____
- Have you had Hepatitis? Yes ☐ No ☐ Venereal Disease? Yes ☐ No ☐ Last HIV test _____

  Results? _____
- Do you now have, or have you ever had, seizures or convulsions? Yes ☐ No ☐

  If yes, when, and what condition caused them? _____When was the last seizure or convulsion? _____

For Women Only:

At what age did you start to menstruate? _____

Do you now have, or have you had, any problems with your menstrual period? ☐ Yes ☐ No

If yes, please describe these problems: _____

Have you had any:

Pregnancies? Yes ☐ No ☐ If yes, how many? _____ When? _____ Were you using? _____

Miscarriages? Yes ☐ No ☐ If yes, how many? _____ When? _____ Were you using? _____

Abortions? Yes ☐ No ☐ If yes, how many? _____ When? _____ Were you using? _____

Menopausal symptoms or treatment? If yes, when?_____

For Men Only:

Do you now have, or have you had, problems with your prostate, difficult or painful urination, or impotence?

Yes ☐ No ☐ If yes, please describe those problems: _____

FAMILY HISTORY (*Please tell us about your immediate family)*

CHILDREN ☐ None

First Name	Last Name	Age	Living With?	Custody?	Quality of Relationship
			Yes / No	Yes / No	
			Yes / No	Yes / No	
			Yes / No	Yes / No	
			Yes / No	Yes / No	

SPOUSE/SIGNIFICANT OTHER ☐ None

Name	Age	Occupation	Quality of Relationship

Relationship	Age	Marital Status	Occupation	Living with?	Quality of Relationship
Mother				Yes / No	
Father				Yes / No	
Sibling:				Yes / No	
Sibling:				Yes / No	
Sibling:				Yes / No	
Other:				Yes / No	

Place of Birth: **Place of upbringing**:

Family is: Intact Parents Separated/Divorced Parents Remarried

Resided with: Mother Father Adopted Orphaned Other:

Health History	Father	Mother	Siblings	Children	Other
Age at Death					
Cause of Death					
Heart Disease/ Stroke					
High Blood Pressure					
Diabetes					
Cancer (type)					
Epilepsy					
Asthma					
Blood Disease					
Other:					

Contact with Family (check all that apply)

☐ Visit at least monthly ☐ Involved with treatment providers ☐ Family is available locally
☐ Supportive ☐ Knowledgeable about mental illness ☐ Family members not available
☐ Non-supportive ☐ Involved in NAMI or other support group ☐ Satisfied with family/relationship contact
☐ Not satisfied with family relationship/contact

SUBSTANCE ABUSE HISTORY

Family Substance Abuse (*Please check any family that apply, and list substance abused)*

☐ None ☐ Parents:_____ ☐ Siblings:_____ ☐ Extended Family:_____

Do you or your family think you have a problem with:

Shopping? Yes ☐ No ☐ Barbiturates? Yes ☐ No ☐ Internet? Yes ☐ No ☐

Sex Addiction? Yes ☐ No ☐ Gambling? Yes ☐ No ☐

Have you had any previous rehab or **treatment of substance abuse?** Yes ☐ No ☐

Where?	Reason there?	How Long?	In patient/ Outpatient?	Date

(Please indicate which of the following drugs you have used, if any)

Substance	Age at first use	How often you use	How much you use	Method (s) you use	How long since last use
Alcohol					
Methamphetamine					
Amphetamine					
Barbiturates					
Cocaine (powder)					
Cocaine (crack)					
Hallucinogens					
Heroin					
Methadone					
Morphine					
Opium					
Inhalants					
Marijuana/Hashish					
PCP (Angel Dust)					
Ketamine (Special K)					
Ecstasy (x)					
Other: _____					

Did/do you go to "meetings?" _____ Do you have a sponsor? _____

Do you see a psychiatrist and if so who and how long? _____

Do you see a therapist or counselor and if so who and how long? _____

Have you ever been treated for depression if so when? _____

LEGAL HISTORY (*Please report any and all legal issues)*

Legal or Criminal Involvement?	Yes / No	*Court order* *Probation* *Parole* *Restraining Order*	
Found not competent to stand trial *Homicide or attempted homicide* *Sexual Assault* *Arson* *Assault* *Felony*			
Probation/Parole Officer	Current / Past	Name:	County:
DUI (date):	**Warrants** (date):		**Violent Crime** (date):
Incarceration, date(s):		How long:	Reason:
Do you have firearms at home?	Yes / No	*If yes,* Are they locked?	Yes / No

MENTAL HEALTH

***Stressful events over the last year*:**

- ☐ Recent Hospital Discharge
- ☐ Death/ Divorce/ Separation
- ☐ Relationship problems
- ☐ Move
- ☐ Educational Problems
- ☐ Housing Problems
- ☐ Access to Healthcare
- ☐ Witness/Victim of Violence
- ☐ History/Current Abuse
- ☐ Disability (self or family)
- ☐ Parenting Issues
- ☐ Job Loss
- ☐ Financial Problems
- ☐ Legal Problems
- ☐ Social/Environmental Problems
- ☐ Other Family Problems
- ☐ Health Problem: _____
- ☐ Other: _____

Please check symptoms experienced in the last 4 weeks:

MOOD ☐ Depression ☐ Anxiety ☐ Hopelessness	☐ Mood Changes ☐ Sadness ☐ Elation (happier than normal) ☐ Anger/Rage	☐ Overwhelming guilt/shame ☐ Difficulty enjoying life ☐ Irritability
BEHAVIORS ☐ Hurting yourself ☐ Doing the same thing repeatedly	☐ Uncontrolled spending/gambling ☐ Increased alcohol/drug use	☐ Reckless behavior ☐ Social Isolation
PHYSICAL ☐ Increased Sleep ☐ Decreased Sleep ☐ Difficulty Sleeping	☐ Panic/ Anxiety Attacks ☐ Increased Appetite/ weight gain ☐ Decreased Appetite/ weight loss ☐ Disturbing nightmares/dreams	☐ Agitation/Restless ☐ Unusual sensory experience (smell, taste) ☐ Other (specify):
THINKING ☐ Wanting to take your life ☐ Wanting to hurt someone else ☐ Seeing/Hearing things that aren't there ☐ Difficulty concentrating	☐ Intrusive negative thoughts ☐ Flashbacks ☐ Irrational fear ☐ Racing thoughts ☐ Paranoia	☐ Low self-esteem ☐ Academic/work problems ☐ Easily distracted ☐ Thinking same thought repeatedly ☐ Memory problems
INTERPERSONAL ☐ Increased conflict w/ others ☐ Increased family conflict ☐ Difficulty making/keeping friends	☐ Socially withdrawn/isolation ☐ Increased sexual problems/concerns ☐ Increased social anxiety ☐ Problems with intimacy	☐ Increased difficulty tolerating others ☐ Trouble with law/authority figures ☐ Intermittent relationships

TREATMENT QUESTIONAIRE

Have you had any previous **psychiatric hospitalizations?** Yes ☐ No ☐

Where	**When**	**Reason**

Have you had any previous **outpatient mental health treatment?** Yes ☐ No ☐

Where	**When**	**Reason**

Have you had any previous **prescribed psychiatric medications?** Yes ☐ No ☐

Medication	**Prescribing Doctor**	**Dates**

Have any family members had a history of **mental illness?** Yes ☐ No ☐

Persons	**Diagnosis or Symptoms**	**Treatments**

Have you ever experienced any **trauma**? Yes ☐ No ☐

If yes, have you been: ☐ Neglected ☐ Physically Abused ☐ Emotionally Abused ☐ Sexually Abused ☐ Don't Know

Any other incidents of **trauma**: ☐ Acts of War ☐ Witness/Victim of violence ☐ Serious Accidents ☐ Fire ☐ Other

Describe:

How are you **sleeping**? (Describe any recent changes or problems)

How is your **appetite**? (Include any recent weight changes)

What **leisure or stress reduction activities** do you use?

Past **interests/activities**:

Do symptoms interfere with your ability to work or get things done? Yes ☐ No ☐

Additional Comments/Information:

The above information is thorough and accurate to the best of my knowledge.

_____ _____

Patient Signature (or Guardian) **Date**