Healthy Driven
Linden Oaks
BEHAVIORAL HEALTH

Preliminary History For New Patients

Name: _____ DOB: _____

Today's Date: _____

Personal Physician: _____
Name

_____
Address, Town, State, Zip

_____
Phone

Medical History

Drug Allergies: _____
Last Exam: _____
Last EKG: _____
Operations: _____
Thyroid Problems: ☐Yes ☐No
Hormone Problems: ☐Yes ☐No
Medical Illnesses: Please describe: _____
_____
_____

Medication: Name : _____ mg _____
Directions: _____
Name: _____ mg _____
Directions: _____
Name: _____ mg _____
Directions: _____

Current History

Reason for Appointment _____
_____
Prior Help _____
_____
Losses in last two years? (deaths, relationships, job, etc.) _____
_____
Current support systems (family, friends) _____
_____

Name: _____ DOB: _____

Social History

Spouse/Children (names, ages) _____

_____

Describe stressors (what upsets, makes you nervous) _____

_____

Job (describe what you do) _____

_____

Leisure activities _____

Alcohol/Drug use/Treatment _____

Family History

Any adoptions (immediate family) _____

Any history of nervous-emotional illness/substance abuse _____

_____

Current Symptoms

Sleep:
- ☐ No Change
- ☐ Too Much
- ☐ Cannot fall asleep
- ☐ Wake too soon
- ☐ Panic at night
- ☐ Tired AMs

Appetite:
- ☐ Increased
- ☐ Decreased
- ☐ Weight Change
- ☐ Binging
- ☐ Vomiting
- ☐ Sweet craving

Concentration:
- ☐ OK
- ☐ Decreased Memory
- ☐ Poor decision making
- ☐ Decreased attention span

Energy:
- ☐ Low
- ☐ High
- ☐ Normal

Anxiety:
- ☐ Occasional
- ☐ Constant
- ☐ Panic
- ☐ Irritable
- ☐ Feel Guilty
- ☐ Obsessive Thoughts

Interest:
- ☐ Social Withdrawal
- ☐ Low Sex Drive
- ☐ Neglect of Hobbies
- ☐ Loss of pleasure when active
- ☐ Loss of desire for usual activities

Mood:
- ☐ Stable
- ☐ Mostly Low
- ☐ Elevated
- ☐ Swings a lot

Suicide Thoughts:
- ☐ Never
- ☐ Occasionally
- ☐ Frequently

Suicide Attempts:
- ☐ Yes
- ☐ No
- ☐ How? _____