LINDA BERLIN, PSY.D. & PSYCHOLOGICAL ASSOCIATES, P.A.
CLINICAL PSYCHOLOGY ~ GENERAL PSYCHIATRY ~ CHILD AND ADOLESCENT PSYCHIATRY

1725 N University Dr., Suite 350
Coral Springs, FL 33071
Tel: (954) 227-2700
Fax: (954) 227-2704

7000 West Palmetto Park Rd. Suite 407
Boca Raton, FL 33433
Tel: (561) 347-0997
Fax: (561) 347-0996

Adult Patient History Form

Provider: Gabriela DePrima, Psy.D.
Licensed Clinical Psychologist
PY # 8009

Appointment Date: ____/_____/_____
Today's Date: ____/_____/_____

IDENTIFICATION

1. NAME: _____ BIRTHDATE: ____/_____/_____

AGE: _____ PLACE OF BIRTH: _____

HOME PHONE: (___)_____CELL PHONE: (___)_____ WORK PHONE: (___)_____

ADDRESS: _____

CURRENTLY EMPLOYED: □ NO □ YES, AS: _____ , EMPLOYER: _____

PRESENTING CONCERNS

1. WHO WERE YOU REFERRED BY? _____

2. WHAT ARE YOUR CONCERNS THAT BROUGHT YOU IN TODAY?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

PRESENTING CONCERNS (CONTINUED)

3. HOW LONG HAVE YOU BEEN AWARE OF THESE CONCERNS?

_____

_____

_____

PSYCHOLOGICAL/PSYCHIATRIC HISTORY

PLEASE INDICATE WHAT TYPE OF TREATMENT YOU HAVE RECEIVED IN THE PAST.

1. THERAPY? □ NO □ YES, FILL OUT BELOW.

Provider Name	Approximate Dates of Treatment	Reasons for Treatment
_____	_____	_____
_____	_____	_____
_____	_____	_____

2. MEDICATION MANAGEMENT: □ NO □ YES, FILL OUT BELOW.

PROVIDER NAME: _____ APPROXIMATE DATES OF TREATMENT: _____

REASONS FOR SEEKING TREATMENT: _____

3. PSYCHIATRIC HOSPITALIZATION □ NO □ YES, FILL OUT BELOW.

FACILITY/HOSPITAL: _____ APPROXIMATE DATES OF HOSPITALIZATION: _____

REASONS FOR HOSPITALIZATION: _____

MEDICATIONS: PLEASE LIST ALL MEDICATIONS OR SUPPLEMENTS TAKEN. *INCLUDE PSYCHIATRIC AND MEDICAL MEDICATIONS.*

MEDICATION NAME	DOSE	FREQUENCY	INDICATION
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

DSM-5 Self-Rated Level 1 Cross Cutting Symptom Measure-Adult

If the measure is being completed by someone else, what is your relationship to the individual? _____
If so, Approximately how much time do you spend with the individual? _____hours/week

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past Two (2) Weeks.**

		During the **past two weeks**, how much (or how often) have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** several Days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain (Office Use Only)**
I	1.	Little interest or pleasure in doing things?	0	1	2	3	4	
	2.	Feeling down, depressed or hopeless?	0	1	2	3	4	
II	3.	Feeling more irritated, grouchy, and Angry than usual?	0	1	2	3	4	
III	4.	Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5.	Staring lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV	6.	Feeling nervous, anxious, frightened, worried or on edge?	0	1	2	3	4	
	7.	Feeling panic or being frightened?	0	1	2	3	4	
	8.	Avoiding situations that make you anxious?	0	1	2	3	4	
V	9.	Unexplained aches and pains (e.g., head, back, joints, Abdomen, Legs)?	0	1	2	3	4	
	10.	Feeling that your illnesses are not being taken seriously enough?						
VI	11.	Thoughts of actually hurting yourself?	0	1	2	3	4	
VII	12.	Hearing things other people couldn't hear, such as voices even when no one is around?	0	1	2	3	4	
	13.	Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII	14.	Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX	15.	Problems with Memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16.	Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17.	Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	

		During the past two weeks, how much (or how often) have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** several Days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain (Office Use Only)**
XI.	18.	Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19.	Not knowing who you really are of what you want out of life?	0	1	2	3	4	
	20.	Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21.	Drink at least 4 drinks or any kind of alcohol in a single day?	0	1	2	3	4	
	22.	Smoke any cigarettes, a cigar, or pipe, or use snuff or chewing tobacco?	0	1	2	3	4	
	23.	Use any of the following medicines ON YOUR OWN, that is without a doctor's prescription [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like Ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamines (like speed)]?	0	1	2	3	4	

MEDICAL HISTORY

1. PRIMARY CARE PHYSICIAN: _____ CLINIC/GROUP NAME: _____

2. CURRENT MEDICAL CONDITIONS/TREATMENT (E.G., ASTHMA, SEIZURES, DIABETES…ETC.):

_____

_____

_____

3. ALLERGIES? □ NO □ YES, DESCRIBE BELOW (RESPIRATORY, ENVIRONMENTAL, FOOD, MEDICATION):

_____

_____

6. PAST SURGERIES?	DATE	LOCATION/HOSPITAL
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____

7. PAST HOSPITALIZATIONS?	DATE	LOCATION/HOSPITAL
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____

DEVELOPMENTAL HISTORY

1. HISTORY OF LEARNING DISABILITIES (E.G., DYSLEXIA, WRITING, MATH)? _____

2. ATTENDED SPECIAL EDUCATION CLASSES? _____

3. RECEIVED ANY DEVELOPMENTAL SERVICES (E.G., PHYSICAL , SPEECH OR OCCUPATIONAL THERAPY)?

_____

SOCIAL HISTORY

1. MARITAL STATUS: □ SINGLE □ MARRIED □ DIVORCED □WIDOWED □ PARTNERED

IF MARRIED OR PARTNERED, HOW LONG? _____

2. WHO DO YOU LIVE WITH? (NAME, AGE, RELATIONSHIP)

_____

_____

3. DO YOU HAVE ANY CHILDREN? □NO □ YES, PLEASE INCLUDE THEIR NAMES AND AGES BELOW

_____

_____

Social History (Continued)

4. Family of Origin:

Who were you raised by? _____ Are They Still Living? □ No □ Yes

Siblings [Name, Age, Relationship (Step, Half, Biological)]?

_____

_____

5. Highest Education Obtained? _____

6. Military History? □No □ Yes, Please describe:_____

7. Arrest History or Pending Legal Issues (E.G., Divorce, Disability, Bankruptcy, Etc.):

_____

_____

Family Psychiatric History

Please indicate if there is a family history of the following conditions and who is affected by the condition:

Condition / Relationship	Condition / Relationship
Anxiety: _____ _____	Autism: _____
Depression: _____	ADHD: _____
Bipolar Disorder _____	Alcoholism: _____
Eating Disorders: _____	Drug Abuse: _____
Learning Disabilities: _____	Suicide: _____

Other Psychiatric Conditions? _____

_____

_____

Goals/Expectations for treatment:

1. Please describe what are your goals/expectations from treatment:

_____

_____

_____