RUTH H STEINMAN, MD

PATIENT INFORMATION

LEGAL Name_____ Date of Birth_____ Preferred

Name (if different from legal name) _____

Address_____ City_____ State_____ Zip_____ Mailing

Address_____ City_____ State _____ Zip_____

(If different) Phone: Primary _____ Secondary _____

(**Best place to reach you or leave a message**) Person responsible for your account

_____ relationship_____

Relationship status: Single Married Partnered Name of Spouse/Partner (parents/guardian for

minor)_____ Children & Ages (siblings for minor)

_____

Name of referring physician _____ In case of emergency notify

_____ Relationship_____Phone_____

REFERRED BY - IF OTHER THAN YOUR DOCTOR_____

Please explain why you are seeking help at this time:

Please explain how your problems are affecting your work and relationships, plus your general functioning:

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On a 1 to 10 scale, with 1 = no distress and 10 = extreme distress, please rate your distress level now:

Please check any health problems you have or have had:

_____lung _____high blood pressure _____arthritis _____liver _____diabetes _____other pain _____kidney _____seizures _____cancer _____stomach/intestinal _____head injury

Medicines you are allergic to:

Medicines you now take:

How much and what kind of exercise you get:

Height _____ Weight _____

SUBSTANCE USE Average amount Past 2 months Most ever used

Coffee _____ _____ Cigarettes _____
_____ Alcohol _____ _____ Recreational Drugs
_____ _____

Please rate your level of difficulty with these problems: 0 = none 1 = mild 2 = moderate 3 = severe

___Physical health ___ In-law problems ___Using drugs ___Chronic Pain ___ Job or school performance ___Panic Attacks ___ Low mood ___Friendships ___Phobias ___ Mood swings ___Financial problems ___ Anxiety symptoms ___ Energy/motivation level ___ Obsessions (unwanted thoughts) ___*sweating* ___ Memory ___ Nightmares ___ *short of breath* ___ Concentration ___ Thoughts of hurting someone ___ *stomach upset* ___ Sleep ___ Compulsions (unwanted actions) ___*dizziness* ___ Sexual functioning ___ Flashbacks ___ *choking* ___Suicidal thoughts ___ Paranoid thoughts ___ *racing heart* ___ Spirituality/religion ___ Domestic violence (verbal) ___ *weakness* ___ Marriage/relationship ___ Domestic violence (physical) ___*dry mouth* ___ Family conflicts ___ Drinking alcohol ___*feeling trapped*

___ *panic*

For the following, please circle YES or NO and give details:

Have you had counseling or psychotherapy in the past? YES - NO _____ Have you ever taken medication for your emotional or mental health? YES – NO _____ Have you ever been hospitalized for psychiatric problems? YES – NO _____ Have you ever been arrested? YES – NO _____ Is there any mental/emotional trouble, alcoholism or drug use, or suicide in your family? YES – NO

Have you ever had any experiences that you would consider traumatic or abusive? YES - NO

Have you ever tried to kill yourself or hurt yourself in any way? YES – NO _____ Is there any danger these days that you might hurt yourself or someone else? YES – NO _____

Please describe your education:

Please describe the family you grew up in including your parents and names and ages of your siblings:

Please describe your marital or domestic partnership history. Include first names of current and past spouses, and your age at the time:

Please describe your support system (family you are close to, friends you talk with, etc.):

What is your current job and how do you like it?