MERCYLAND PSYCHIATRY
530 W. Main St., Sun Prairie, WI 53590

Last name: ____ First name: ____

Birthdate: ____

Primary Care Provider:

Yes	No	
☐	☐	Do you regularly see a primary care provider? Who is your primary care provider? ____ Where is he/she located? ____
☐	☐	Have you had a physical in the last year? When? ____
☐	☐	Have you had any hospitalizations for medical reasons in the last year? If yes, please list: ____ ____
☐	☐	Do you have any allergies? If yes, please list: ____ ____

Medications (Include vitamins, supplements, and any over-the-counter medications):

Medication	Dose	Date you started medication	Reason for taking medication	Medication prescribed by

Sleep:

How many hours of sleep do you get a night? ____

Yes	No	If you answer yes, give the reason for the sleep problem, if known.
☐	☐	Do you have problems falling asleep? ____________________________________
		____
☐	☐	Do you have nightmares? ____________________________________
		What are they about? ____________________________________
☐	☐	Do you feel rested when you wake up? ____________________________________
☐	☐	Do you use a CPAP machine? ____________________________________
☐	☐	Do you take any sleeping medication? ____________________________________
☐	☐	Do you have any other sleep issues? ____________________________________
		____

Nutrition:

How many meals do you eat per day? ____

How much caffeine do you drink per day? ____

How many energy drinks do you drink per day? ____

Beliefs/attitude about food:

Yes	No	Include how much and the reason why.
☐	☐	Have you gained weight in the past year? ____________________________________
☐	☐	Have you lost weight in the past year? ____________________________________
☐	☐	Are there any foods you fear due to calories, fat, etc? ____________________________________
☐	☐	Are there any foods that you won't eat? ____________________________________

Behaviors around food:

Yes	No	Past	Present	
☐	☐	☐	☐	Do you purge (force yourself to throw up)?
☐	☐	☐	☐	Do you overeat?
☐	☐	☐	☐	Do you restrict your food intake?
☐	☐	☐	☐	Do you take laxatives or diet pills?
☐	☐	☐	☐	Do you have negative thoughts about your body or looks?

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Exercise:

Yes	No	
☐	☐	Do you currently engage in exercise that raises your heart rate?

What type of exercise do you engage in? ____

____

How often per week do you exercise? ☐ 1-2 days ☐ 3-4 days ☐ 5-6 days ☐ 7 days
How long are the exercise sessions? ☐ 0-15 min ☐ 15-30 min ☐ 30-45 min ☐ 45-60 min

Smoking:

Yes	No	
☐	☐	Do you currently use tobacco products? If yes, what type? ______________________________
☐	☐	Have your tried to quit? If yes, how many times? ______________________________
☐	☐	Do you want resources on how to quit smoking?

Current/Past Substance Use/Abuse: If not applicable, check here ☐.

Substance	Currently Using		Past Use		How often do you use?	Date of last use
Alcohol	☐ Yes	☐ No	☐ Yes	☐ No		
Cocaine	☐ Yes	☐ No	☐ Yes	☐ No		
Heroin	☐ Yes	☐ No	☐ Yes	☐ No		
Marijuana	☐ Yes	☐ No	☐ Yes	☐ No		
Pills	☐ Yes	☐ No	☐ Yes	☐ No		
IV drug use	☐ Yes	☐ No	☐ Yes	☐ No		

Firearms:

Yes	No	
☐	☐	Are there firearms in your home/apartment?
☐	☐	Are they locked in a cabinet?
☐	☐	Is the gun locked?

Past/Current Medical Health Issues:

Have you been treated for or experienced the following?

Yes	No	If you answer yes, explain how often you experience the condition, the length of illness, if you are currently being treated and by whom.
☐	☐	Muscle tension? ______
☐	☐	Headaches? ______
☐	☐	Migraines? ______
☐	☐	A traumatic head injury (if yes, open or closed)? ______
☐	☐	Epilepsy or seizure disorder? ______
☐	☐	Heart or lung disease? ______
☐	☐	Hypoglycemia (low blood sugar)? ______
☐	☐	Diabetes? ______
☐	☐	Hypertension (high blood pressure)? ______
☐	☐	Thyroid? ______
☐	☐	Cancer? ______
☐	☐	Arthritis? ______
☐	☐	Multiple episodes of strep throat? ______
☐	☐	Recurrent ear infections? ______
☐	☐	Ever had a broken bone? ______
☐	☐	Are you frequently in pain? ______
☐	☐	Are you seeing anyone for your pain? ______
☐	☐	Have you ever tested positive for TB? ______
☐	☐	Were you treated for TB? ______
☐	☐	Any other medical problems? ______

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Risk Factors for Infectious Disease:

Have you been treated for or experienced the following?

Yes	No	If you answer yes, explain how often you experience the condition, the length of illness, if you are currently being treated and by whom.
☐	☐	Do you have/had unprotected sex with multiple partners? ____
☐	☐	Have you been treated for a STD? ____
☐	☐	Have you tested positive for HIV? ____
☐	☐	Are you currently pregnant? ____
☐	☐	Have you ever had a miscarriage? ____
☐	☐	Have you ever had an abortion? ____
☐	☐	Have you had a blood transfusion? ____

Please Circle the Number that Best Matches Your Response:

Rate your current physical health:

1	2	3	4	5	6	7	8	9	10
Poor									**Excellent**

How is your physical health impairing your current ability to function?

1	2	3	4	5	6	7	8	9	10
Not at all									**Severely**

Rate your current mental health:

1	2	3	4	5	6	7	8	9	10
Poor									**Excellent**

How is your mental health impairing your current ability to function?

1	2	3	4	5	6	7	8	9	10
Not at all									**Severely**

____ ____________________

Patient/Guardian Signature Date Time