Ocoee Behavioral Health

Adult Behavioral Health Impression

Name:_____

Date:_____

Date of birth:_____

Primary Physician:_____

Referring Physician:_____

Reason you are here:

_____

_____

_____

What would you like to achieve from treatment here?_____

_____

_____

Please list your medications:

_____ _____

_____ _____

_____ _____

Behavioral Health History

Are you experiencing or have you ever experienced the following:

Depressive symptoms? (Ex. Sadness most of the day, loss of interest in activities, loss of energy, recurrent thoughts of death or suicide, feeling worthless or guilty) **Y / N**

If yes, please tell how long? When did the symptoms start?

_____

_____

Suicidal or homicidal thoughts? **Y / N** If yes , please describe._____
_____
_____

Mood swings (Ex. Days without sleep and high energy, followed by days of depression, flight of ideas, unusual pressure to keep talking, highly risky or impulsive behaviors) **Y / N**

Anxiety symptoms (Ex. Excessive worry, feeling on edge, irritability, can't concentrate, panic attack) **Y / N** If yes, for how long?_____

Psychosis symptoms (Ex. Auditory, visual hallucinations) **Y / N** If yes for how long?_____

ADHD symptoms (Ex. Inattention, hyperactivity, disorganization, doesn't seem to listen, easily distracted**. Y / N** If yes for how long?_____

Conduct Behavior (Ex. Loses temper, aggression, bullies others, theft, fire setting, deceitfulness)

Y / N If yes for how long?_____

Past behavioral health treatment? **Y / N** IF **NO** SKIP next 5 questions and answer about substance abuse.

Current or past psychiatrist:_____

Have you tried other medications that you are no longer taking? **Y / N** If yes please list them._____
_____
_____

Current or past therapist/counselor._____

Inpatient hospitalizations for behavioral health issues. **Y / N**
_____

Do you have a family member that has a history of behavioral health diagnosis or substance abuse problems? **Y / N** If yes please provide some details_____
_____

Do you have a substance abuse history? **Y / N** If yes please provide details._____
_____
_____

Recreational drugs? **Y / N** If yes drug of choice_____
_____

When did you start?_____

Use of Alcohol? **Y / N** If yes how often._____

Caffeine? **Y / N** If yes how often._____

Cigarettes? **Y / N** If yes how often._____

Any legal consequences because of your substance use? **Y / N** If yes explain._____
_____

Social History

Current living situation:_____

Marital status:_____

Siblings:_____

Children:_____

Education level:_____

Where do you work?_____

Are you receiving disability? **Y / N** If yes how long?_____

Have you ever experienced abuse (physical, sexual, neglect as a child, domestic violence) or other trauma? **Y / N** If yes please briefly describe_____
_____
_____

Do you still experience nightmares because of the traumatic event? **Y / N**

Do you try to avoid anything that reminds you of the traumatic event? **Y / N**

Are you on edge and hyper alert about things since the event happened? **Y / N**

What do you like about
yourself?_____
_____
_____

Medical History

Do you have current medical issues that you are addressing? **Y / N** if yes please explain
_____
_____

Past medical procedures? **Y / N** If yes please provide brief information.
_____
_____

Past surgeries? Y / N If yes provide brief information.
_____
_____

Legal Issues

Have you been arrested? Y / N If yes please briefly describe.
_____
_____

Do you currently have any pending charges or warrants?
_____
_____

What have you tried in the past to cope with the issue that brought you here today?
_____
_____
_____
_____
_____