PATIENT HISTORY INTAKE FORM **Provider:** Dennis A. Marikis, Ph.D.

YOUR FULL NAME: ____ DATE OF BIRTH: ____________

ADDRESS: ____

BEST CONTACT PHONE NUMBER:____

Is anyone helping you complete this form? ☐ *NO* ☐ *YES name & relationship:* ____________________

____

1. Please explain reason for this assessment: ☐ BWC ☐ Firefighter/Police Officer ☐ Ministerial Assess. ☐ Psychological Evaluation ☐ Social Security ☐ Spinal Cord Stimulator ☐ Other

____

____

2. Have you been treated by a psychiatrist/psychologist? ☐ NO ☐ YES

   If yes, where / when did you start and how often______________________________________

3. Have you been hospitalized for the above listed psychiatric condition(s)? ☐ NO ☐ YES

   If yes, where / when / why? ____

4. Please list any medication(s) you have been prescribed related to this condition(s):

   1. _________________________________ 4. _________________________________
   2. _________________________________ 5. _________________________________
   3. _________________________________ 6. _________________________________

5. Who is your medical physician of record? ____

FAMILY HISTORY:

1. Where were you Born? ______________________________ Raised? ______________________________
2. Were your parents… ☐ Married? ☐ Divorced / Separated? ☐ Never Married?
3. Do you stay in touch with siblings? ☐ NO ☐ YES
4. Are either of your parents deceased? ☐ NO ☐ YES: Who / When ____________________
5. Did you or anyone in your family suffer from…
   - ☐ Mental Illness; If yes, who? ____
   - ☐ Alcohol Abuse; If yes, who? ____
   - ☐ Drug Abuse; If yes, who? ____
   - ☐ Sexual Abuse; If yes, who? ____
   - ☐ Physical Abuse; If yes, who? ____
6. Did you have any significant medical illness or injury during your childhood? ☐ NO ☐ YES

   If yes, please explain: ____

MARITAL STATUS:

1. Have you been ☐ Married; # of times _________ ☐ Divorced; how long? ___________________

   ☐ Never Married ☐ Widowed; when? _______________ ☐ Separated; how long? ______

2. If currently married, how many years? ________________________ (continued)

MARITAL STATUS (continued):

3. How many…. Birth Children? _____ If any… ☐ boys; ages ________ ☐ girls; ages ________
   Step Children? ________ If any… ☐ boys; ages ______ ☐ girls; ages ______ Any adopted? ________
4. With whom do you live? ____
5. If you have children who do not live with you, do you have regular contact with them? ☐ NO ☐ YES
6. Do you live in the ☐ City / Urban ☐ Country / Rural ☐ Suburbs

SUBSTANCES

1. Do you have a history of, or are you currently using non-prescription drugs (street drugs?)
   ☐ NO ☐ YES; what and how often? ____
2. Do you have a history of, or are you currently consuming alcohol to the point of abuse?
   ☐ NO ☐ YES; what and how often? ____
3. Have you ever been in a drug or alcohol treatment program? ☐ NO ☐ YES
   If yes, when and where? ____
4. Have you ever been convicted of a DUI? ☐ NO ☐ YES; How long ago? __________________
5. Do you smoke cigarettes? ☐ NO ☐ YES; How many a day? ______________________________
6. Have you ever been arrested? ☐ NO ☐ YES; when and why? ________________________

Check and circle if you have experienced any of these symptoms [example:__flushes, chills, hot flashes]

__Trembling, twitching, feeling shaky
__Shortness of breath, smothering sensation
__Racing heart, heart palpitations, chest pain
__Moist palms, excessive sweating
__Dizziness, lightheadedness, blackouts
__Nausea, diarrhea, other abdominal distress
__Flushes, chills, hot flashes
__Numbness, tingling sensation
__Trouble swallowing, choking sensation, dry mouth
__Feeling you or things around you aren't real
__Frequent headaches, muscle aches
__Frequent urination
__Nervousness, feeling edgy, startle easily
__Irritability (lose temper easily), restlessness
__Excessive worry, unreasonable fears
__Difficulty concentrating, easily distracted
__Tire easily, low energy level
__Increased or decreased sleep (Average hours per night ____)
__Loss of interest in many or most activities
__Increased or decreased appetite (Amount of weight change ______)
__Suicidal thoughts, gestures, attempts
__Period of inflated self-esteem or excessive self-importance
__Excessive involvement in pleasurable activities (such as sex or spending) which results in major problems
__Periods of purposeful but excessive activity
__Unusually long periods of high energy or activity without need for rest
__Excessive hand-washing, fear of germs
__Excessive checking (doors, locks, stoves)
__Annoying thoughts that won't go away
__Hearing voices
__Self-induced vomiting, binge eating
__Excessive exercise, strict dieting
__Use of laxatives, dietetics
__Careless mistakes in school, work or other activities
__Can only pay attention for short periods at school, work, home
__Failure to complete school work, chores or other duties
__Hyperactive: fidgets, squirms, talks excessively
__Acts without thinking of consequences
__Forgetful in daily activities
__Daydream frequently
__Often loses things necessary for tasks
__Feelings of hopelessness
__Self-harm (self-mutilation)
__None of the above

List major operations, serious injuries, hospitalizations: None________

Date	Description	Present Condition

(continued)

Have you ever suffered from a head injury: _____ Yes _____ No

If yes, when?______________________________ Did you lose consciousness: ___________

List of current medications, both prescription and over the counter: (If you have a list, someone will gladly copy it.)

Name of Medication	Amount/Dosage	Frequency	Purpose

JOB HISTORY:

What jobs have you done and for how long? (For example: Manager 10 years)

1. ______________________________ 4. ______________________________
2. ______________________________ 5. ______________________________
3. ______________________________ 6. ______________________________

What is your current job status? ☐ Unemployed ☐ Retired

☐ Currently working? For whom and how long? ____

EDUCATION:

1. Did you graduate from high school? ☐ NO ☐ YES
2. Were you in ☐ Regular Education ☐ Special Education ☐ Vocational Education
3. Were you in extra activities? ☐ Sports ☐ Clubs ☐ Band ☐ Choir ☐ None
4. How were your average grades in school? ☐ A's ☐ B's ☐ C's ☐ D's ☐ F's
5. Were you ever held back or had to repeat a class or grade? ☐ NO ☐ YES; which? ______
6. Did you have any issues with your behavior while in school? ☐ NO ☐ YES

   If yes, were you … ☐ Suspended ☐ Expelled
7. Were you in the Military? ☐ NO ☐ YES; which branch? ________________________

   If yes, were you ☐ Honorably Discharged ☐ Dishonorably Discharged ☐ Retired
8. Did you have further training after high school? ☐ Vocational School ☐ College

   Specialized Training (Nursing, mechanic, etc.) ☐ Specify ____________________________________

   If yes, did you attain your certificate/degree? ___________

Signing this form indicates that I am aware of and in approval of this evaluation.

____
Signature

____
Date