PSYCHIATRIC HOLISTIC HEALTH

DESA & ASSOCIATES, LLC
319 Littleton rd, Suite 202
Westford, MA 01886
Phone : (978)692-0096 Fax: (978)692-0188

Name: _____ _____ _____DOB_____
First Last Middle

Reason for visit :_____

_____

Psychiatric Diagnosis: _____

Medical Diagnosis:_____

Primary physical complaints: _____
_____

Are you currently under the care of any other physician or health care professional? Yes No If yes, Doctor's name: _____ Specialty:_____
Reason for care:
_____
_____Date of last visit:_____

MaritalStatus: S M D W Separated

Are you applying for disability? _____If yes please explain_____
_____
Health History:_____
Illness or Injury Approx. Date Complications/Comments Full Recovery? Yes No
_____
_____
_____
Surgery Approx. Date Complications/Comments Full Recovery? Yes No
_____
_____
_____
Family History: Cancer__ Diabetes__ Heart Problems__ Mental Illness_____
_____
_____
Other _____ Please explain:
_____
_____

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What time(s) of the day are you most tired? _____ Bowel

movements: >1/day___ 1/day___ Every 2 days___ 3/week___ 2/week___Other____

Current Medications/Supplements:
Please include prescription drugs as well as over the counter medications and supplements.

Medications:_____
_____
Dosage: _____
Purpose: _____
Side Effects:_____
_____

Menstrual History:

Date of last menstrual cycle:_____ Are your cycles regular? Yes No

If no, please explain:_____ Menstrual

Cramping: Yes No If yes: Slight ___ Moderate ___ Severe ___ Other PMS symptoms: Yes No

Please indicate: Bloating ___ Cravings ___ Back Pain ___ Moodiness ___

Other_____

Are you currently pregnant? Y / N Weeks: ___ Complications: _____

Birth Control Information:

Have you ever used hormonal-type birth control (ie: patch, pill, injection, implant, IUD)? Y / N

Are you currently on hormonal-type birth control? Y / N Total years taken?:_____ Reason for starting? PMS ___ Irregular cycle ___ Birth Control ___ Other _____

Appetite and Eating:
How would you describe your appetite? Excellent Good Fair Poor Have your eating habits changed within the past few days/weeks/months: Yes No If yes, please list changes_____

Do you struggle with restrictive or binge eating? _____

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Are you currently or have you ever received treatment for an eating disorder? _____

Are you following any diets/food plans?_____

Diabetes Yes No

Low fat/Low Cholesterol Yes No Weight Loss Yes No Low Sodium/No Salt Yes No
Other:_____

Please list any known food allergies or sensitivities:_____
_____
Have you ever or do you currently smoke? Yes No If quit, how long ago? _____ Quantity:

Less than 10/day 10-20/day More than 20/day

How often do/did you drink alcoholic beverages? Daily Weekly Monthly Never
Is your drinking problematic to others? YES___ No_____

Are you currently in recovery? Yes No

Do you currently use any illicit drugs? (please specify) _____

Do you have a history of using drugs? Yes No Are you currently in recovery? Yes No

Are you able to do physical activity? Yes No If so, how often are you active? _____

Please list types of exercises/activities you enjoy_____

Symptom Profile: PLEASE FILL OUT COMPLETELY

Please circle the symptoms that are relevant to you and list approximate date of start and frequency of experience in space given.

Suicidality: Y/N If so, please indicate: Thoughts: Y/N Plan: Y/N Intent: Y/N Hist. of attempts: Y/N
Immediate need for food, shelter, safety, or medical care (please describe): _____
_____

Loss of Interest _____ Hopelessness _____

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Grief/Loss _____ Depressed Mood _____

Fatigue/Low Energy _____ Difficulty Concentrating _____

Recent increased or decreased need for sleep
_____

Recent change in appetite (please describe)
_____

Please describe your symptoms:

Desire/Acts of self-harm (please describe) _____

Mood Swings
_____

Expansive/Elevated Mood
_____

Risky Behavior _____

Irritability _____

Anger _____
Impulsiveness _____
Thoughts/Desire to harm others:
_____
Anxiety/Worry _____
Racing Thoughts _____
Neck stiffness/pain _____
Back stiffness/pain _____
Pain elsewhere in the body (please describe)
_____
Difficulty falling asleep_____
Difficulty staying asleep _____

Tired upon awakening _____ Nightmares _____
Digestive difficulties (please describe)_____

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Allergies/Sinus Problems _____

Headaches _____ Memory Challenges _____
Blacking out
_____
Loss of Time _____ Dissociation _____
Flashbacks _____ Startle Easily _____
Emotionally Numb _____ Panic _____
Substance Abuse _____ Challenges with Food/Eating _____
Weight Related Issues _____
Sexual Issues _____
Relationship Difficulties (please describe) _____
Other (please list): _____
_____
_____
_____
Mental/Emotional/Relationship Health_____
_____
If you are seeking support around solely physical concerns, this section is optional.
Please describe your presenting concerns in as much detail as possible: _____
_____
_____
_____
_____
_____
What are your goals for medication? _____
_____
_____
Have you been in therapy before? (Please list) _____
_____
_____

Have you ever been in an inpatient or residential psychiatric facility? (Please list names and dates and reason):
_____
_____ ___

Current Medications:_____
_____

_____

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Past Psychiatric Medications. Please provide dates, how long you took them, who prescribed and why did you stop?

_____

_____

_____

Prior Mental Health Diagnoses:_____

_____

Which of the above medications has been helpful for you and why?_

_____

_____

What medications has not been helpful and why not?

_____

_____

Patient History:

Please briefly describe the family you grew up in (members, dynamics, experiences, etc.):

_____

Please briefly describe your current family: _____

_____

Other significant relationship history: _____
_____

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Who provides you with emotional support?_____

Educational level/history:
_____

Occupational history:
_____

Leisure interests:
_____

Spiritual, religious, and cultural practices: _____

Personal strengths: _____

Personal challenges or weakness:
_____

Are you now experiencing, or have you ever experienced, any of the following events? If yes, please list age of occurrence, by whom, and whether the event occurred once or more.

Physical assault or abuse:_____Yes No

Sexual assault or Physical Abuse
_____ Yes No

Emotional or verbal abuse:_____
_____ Yes No

Parental neglect: _____ Yes No

Domestic violence: _____ Yes No

Violent crime: _____ Yes No

Trauma History (please list)f :_____
_____

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Please thoroughly describe how you believe these experiences have impacted or affected you:
_____
_____
_____

What else do you want to be sure that we know about you? _____
_____
_____
_____

Thank you for filling this document out thoroughly! Your time and attention will truly help us to help you to the best of our ability!

I hereby certify that the content disclosed within these pages is accurate and complete to the best of my knowledge.

_____Date_____
Print Name Patient/Guardian

_____ Date_____

Patient/Guardian Signature