Clinical Interview Form

Date: March 23, 2023

Patient's Full Name: Minnie Lester Phone number: (318) 298-887

Date of Birth: 6/11/1985 Address: Grant View Drive, Milwaukee, WI

Gender: F Race: American Age: 38

Emergency Contact (Name, #, and Relationship): Brenda Lester, (270) 804-5113, Mother

Specifics of the problem(s) for which you are seeking help?

Anxiety affecting the different areas of her life. Often feels nervous.

Current Symptoms Checklist:

✓ - present symptoms ✓✓ - major symptoms

Note: For those with an asterisk (*), please write your answer from the options in the parentheses.

[ ] Depressed mood

[ ] Loss of interest in friends and activities

[ ] Poor Concentration/Memory/Forgetfulness

[ ] Fatigue/Low Energy

[✓] Can't Turn Mind Off/Racing Thoughts

[✓] Impulsive Behavior

[✓] Increase Risky Behavior

[ ] Overly Energetic

[ ] Increased Irritability

[ ] Excessive worry/crying spells

[ ] Hallucinations

[✓] Inappropriate Social Behavior

[✓] *Sleep pattern disturbance (Decrease/Increase) Decrease

[ ] *Change in appetite (Decrease/Increase)

[ ] *Libido (Decrease/Increase)

[✓] *Attacks (Panic/Anxiety) Panic

[ ] *Harmful thoughts (Suicidal/Homicidal)

[ ]

[ ]

[ ]

[ ]

Other symptoms:

How long have you been experiencing these symptoms: For a few years.

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Personal and Family Medical History

- [x] Anemia - [ ] You / [x] Family (Family Member: Mother)
- [ ] Liver Disease - [ ] You / [ ] Family (Family Member:)
- [ ] Kidney Disease - [ ] You / [ ] Family (Family Member:)
- [x] Diabetes - [ ] You / [x] Family (Family Member: Grandmother)
- [ ] Asthma/Respiratory Problems - [ ] You / [ ] Family (Family Member:)
- [ ] Cancer (type: _____) - [ ] You / [ ] Family (Family Member:)
- [ ] Heart Disease - [ ] You / [ ] Family (Family Member:)
- [ ] Epilepsy/seizure - [ ] You / [ ] Family (Family Member:)
- [ ] High Cholesterol - [ ] You / [x] Family (Family Member:)
- [x] High Blood Pressure - [ ] You / [x] Family (Family Member: Father)
- [ ] Liver Problems - [ ] You / [ ] Family (Family Member:)
- [x] Other (Vertigo) - [ ] You / [x] Family (Family Member:)

Any additional personal or family medical history?

None.

Were there any complications during your mother's pregnancy or birth with you?

None.

Do you have any physical health concerns you would like to discuss?

None.

For women only:

When was your last period? 3/7/2023 Do you have regular periods? [x] Yes [ ] No

Are you currently pregnant or may be pregnant? [ ] Yes [x] No

Do you have plans of getting pregnant in the future? [x] Yes [ ] No

How many times have you been pregnant, and what were your birthing methods?

None.

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Family Psychiatric History

☐ Bipolar Disorder	(Family Member: _____)
☐ Depression	(Family Member: _____)
☐ Anxiety	(Family Member: _____)
☐ Suicide	(Family Member: _____)
☐ Schizophrenia	(Family Member: _____)
☐ Post-traumatic stress	(Family Member: _____)
☑ Alcohol Abuse	(Family Member: Brother)
☐ Other substance abuse	(Family Member: _____)
☐ Violence	(Family Member: _____)
☐ Anger	(Family Member: _____)
☐ Other (_____)	(Family Member: _____)
☐ Other (_____)	(Family Member: _____)

Has any family member been treated with psychiatric medication? If yes, what were the medication/s, and were they effective?

None.

Personal Physical History, Psychiatric History, and Medication Evaluation

Do you exercise regularly? How many days do you exercise and for how long? What kind of exercise do you do?

Yes. 30 minutes on a treadmill. 3 times a week.

Are you currently in therapy? Have you had therapy in the past? What was the date and duration? Was it helpful?

No.

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Have you received outpatient treatment? If yes, please state the reason, date treated, and physician in charge.

Reason	Date Treated	Physician in Charge

Have you been admitted to a psychiatric hospital? If yes, please state the reason, the date hospitalized, and the hospital's name.

Reason	Date Hospitalized	Hospital Name

Please list ALL your prescription and over-the-counter medications and supplements - current and past - their daily dosage, and estimated start date.

Medications/Supplements	Daily Dosage	Estimated Start Date

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Please list ALL of the medications you've taken for your mental health - current and past -, their dosages, and your response or side effects.

Medications/Supplements	Daily Dosage	Estimated Start Date

Please list ALL allergies you have to any of the following: medications, food, and substances and corresponding reaction to them.

Allergies	Reaction
Nuts.	Difficulty Breathing.

Substance Use

Do you currently consume any of the following? If yes, how many a day?

☑ Coffee	Frequency:	1
☐ Soda	Frequency:	
☑ Tea	Frequency:	1
☑ Alcohol	Frequency:	1
☐ Tobacco	Frequency:	

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Substance Use

If you had consumed them in the past, how many would you consume a day minimum/maximum?

☑ Coffee	Minimum:		Maximum:	1
☐ Soda	Minimum:		Maximum:	
☑ Tea	Minimum:		Maximum:	1
☑ Alcohol	Minimum:		Maximum:	3
☐ Tobacco	Minimum:		Maximum:	

Have you ever tried any of the following? If yes, when did you last use it and for how long have you been using it/ how often do you use it?

☐ Methamphetamine	Last date:	Duration:	Frequency:
☐ Cocaine	Last date:	Duration:	Frequency:
☐ Stimulants (pills)	Last date:	Duration:	Frequency:
☐ Heroin	Last date:	Duration:	Frequency:
☐ LSD or Hallucinogens	Last date:	Duration:	Frequency:
☐ Marijuana	Last date:	Duration:	Frequency:
☐ Methadone	Last date:	Duration:	Frequency:
☐ Sleeping Pills	Last date:	Duration:	Frequency:
☐ Ecstasy	Last date:	Duration:	Frequency:
☐ Others (_____)	Last date:	Duration:	Frequency:

Has anyone raised any concerns with your alcohol or drug use? Have they felt annoyed about your alcohol or drug use? Do you drink or use drugs first thing in the morning to steady your nerves or get rid of a hangover? Do you think you may have a problem with alcohol or drug use?

Parents and friends have raised their concerns. I used to drink to ease my nervousness. I may have had one before but not anymore.

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Family Background and Childhood History

Possible Guiding Questions:

Were you adopted? Where did you grow up? Do you have any siblings? What are their ages? Parents' occupations? Parents' relationship with each other? Has anyone in your immediate family passed away? How old were you when you left your home?

I am not adopted. Grew up in WI where I was born. I have one brother and sister. Brother, older by 2 years. Sister, younger, by 3 years. My parents are in a loving relationship. I left my home when I was 25, when I had a better paying job.

Educational History

Possible Guiding Questions:

Are you enrolled in school now? Are you a full-time or part-time student? Highest grade completed? How well did you do in school? How were your relationships with your teachers and peers? Were there any experiences worth nothing (i.e., bullying, being diagnosed with a learning disability, being suspended, failing, attended special classes, moving frequently, etc.)

No. I was a full-time student and graduated university. I did fairly well. I didn't fail. I had close friends in school and teachers were helpful with answering any questions I had. I was occasionally bullied before university.

Occupational History

Possible Guiding Questions:

Are you currently employed? What are your hours worked per week? What is your occupation? Where do you currently work? How long have you been employed? Have you served in the military? If so, which branch and when? What type of discharge have you received?

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I am currently employed as an accountant and work 40 hours a week. I work at an accounting firm and have been working there for 3 years now. I haven't served in the military.

Legal History

Possible Guiding Questions:

Have you been arrested? Have you been involved in any court proceedings? Have you ever spent time in jail or prison? Do you have other legal problems?

I haven't.

Spiritual Life

Possible Guiding Questions:

Do you belong to a particular region or spiritual group? What is your level of involvement? Is your involvement helpful to your current situation? If yes, why? If not, why not?

I don't.

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Is there anything else you would like us to know about?

None.

Patient's Signature: Minnie Lester

Date: 3/23/2023

Reviewed by: Dr. Eliza Keomany

Date: 3/23/2023