Clinical Interview Form

Date: ____________________

Patient's Full Name: ____________________ Phone number: ____________

Date of Birth: ____________ Address: ____________________

____________________ Gender: ________ Race: ____________ Age: ______

Emergency Contact (Name, #, and Relationship): ____________________

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

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) ____________
[ ] *Change in appetite (Decrease/Increase) ____________
[ ] *Libido (Decrease/Increase) ____________
[ ] *Attacks (Panic/Anxiety) ____________
[ ] *Harmful thoughts (Suicidal/Homicidal) ____________
[ ] ____________________
[ ] ____________________
[ ] ____________________
[ ] ____________________

Other symptoms: ____________________

How long have you been experiencing these symptoms: ____________________

Clinical Interview Form

Personal and Family Medical History

- ☐ Anemia - ☐ You / ☐ Family (Family Member: ______________)
- ☐ Liver Disease - ☐ You / ☐ Family (Family Member: ______________)
- ☐ Kidney Disease - ☐ You / ☐ Family (Family Member: ______________)
- ☐ Diabetes - ☐ You / ☐ Family (Family Member: ______________)
- ☐ 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 / ☐ Family (Family Member: ______________)
- ☐ High Blood Pressure - ☐ You / ☐ Family (Family Member: ______________)
- ☐ Liver Problems - ☐ You / ☐ Family (Family Member: ______________)
- ☐ Other (________) - ☐ You / ☐ Family (Family Member: ______________)

Any additional personal or family medical history?

____

____

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

____

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

____

____

For women only:

When was your last period? ______________ Do you have regular periods? ☐ Yes ☐ No

Are you currently pregnant or may be pregnant? ☐ Yes ☐ No

Do you have plans of getting pregnant in the future? ☐ Yes ☐ No

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

____

Clinical Interview Form

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: ______________)
- ☐ 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?

____

____

____

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?

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

Clinical Interview Form

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

Clinical Interview Form

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

Substance Use

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

- [ ] Coffee — Frequency: ____________________
- [ ] Soda — Frequency: ____________________
- [ ] Tea — Frequency: ____________________
- [ ] Alcohol — Frequency: ____________________
- [ ] Tobacco — Frequency: ____________________

Clinical Interview Form

Substance Use

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

- ☐ Coffee — Minimum: ____________ Maximum: ____________
- ☐ Soda — Minimum: ____________ Maximum: ____________
- ☐ Tea — Minimum: ____________ Maximum: ____________
- ☐ Alcohol — Minimum: ____________ Maximum: ____________
- ☐ 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?

Clinical Interview Form

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?

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.)

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?

Clinical Interview Form

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?

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?

Clinical Interview Form

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

Patient's Signature: ______________________

Date: ______________________

Reviewed by: ______________________

Date: ______________________