Psychiatric History of Present Illness

Patient Name Date

Date of Birth

Please briefly describe your reason for seeking psychiatric treatment:

Please describe your symptoms (include duration, onset, triggers if any):

How are you functioning at home, work, school, etc?

If you are currently taking medications, what are they? Have the medications been helpful? Are there any side effects?

What are your current stressors?

Please answer yes or no to the following screening questions:

Do you feel depressed?	Y/N
Are you experiencing changes in your sleep?	Y/N
Are you experiencing changes in your appetite or eating habits?	Y/N
Are you self-critical?	Y/N
Do you have thoughts of death or suicide?	Y/N
Do you cry frequently?	Y/N
Are you having difficulty concentrating or remembering things?	Y/N
Do you feel tired or withdrawn?	Y/N
Have you lost interest in usually enjoyable activities?	Y/N
Have you ever experienced a period of unusually elevated or extremely irritable mood?	
Have you ever experienced decreased need for sleep?	Y/N

Do you worry excessively?	Y/N
Do you ruminate or obsess over certain ideas?	Y/N
Do you feel the urge to do things to relieve your anxiety?	Y/N
Do you have sleep disturbance?	Y/N
Do you have muscle tension?	Y/N
Do you have difficulty focusing?	Y/N
Do you experience nightmares?	Y/N
Do you often feel irritable or overwhelmed?	Y/N

Do you ever have experiences that seem bizarre or unreal? Y/N
Do you experience things that others around you do not? Y/N
Do you have thoughts that others find unbelievable or bizarre? Y/N

Do you have difficulty with losing your place in conversation? Y/N
Do you have trouble focusing while reading or working? Y/N
Do you act impulsively or speak out of turn? Y/N
Do you struggle with lack of organization? Y/N
Do you have difficulty completing tasks or with procrastination? Y/N

Do you consume far fewer calories than what you consider to be adequate? Y/N
Are you concerned about your weight? Y/N
Do you ever induce vomiting or use laxatives due to concern about your weight? Y/N

Do you have difficulty in relationships? Y/N
Do you struggle with intense emotions? Y/N
Do you think you perceive things differently than most other people? Y/N

Are you impulsive? Y/N
Are you easily frustrated? Y/N
Do you ever hurt yourself intentionally? Y/N

Do you use any drugs? Y/N
Do you drink alcohol? (if no, then skip the last 3 questions) Y/N
Do you feel the need to reduce your alcohol intake? Y/N
Do you feel guilty about your alcohol consumption? Y/N
Do you ever feel annoyed by others' comments about your drinking? Y/N
Do you ever need alcohol first thing in the morning? Y/N