PATIENT MEDICAL / PSYCHOLOGICAL ASSESSMENT FORM
Saucier Wellness Center

Name: _____ CLID #: _____ Today's Date: _____

Date of Birth / Age: _____/____ Phone #: _____ E-mail Address: _____

Name of Parent / Spouse – Phone Number: _____

SOCIAL HISTORY:

Marital Status: ____; # of children (ages): ___/_____; Religion: _____; Ethnic Origin: _____
Residence: On Campus: ____; Off Campus: ____; Relation of Individuals sharing Residence: _____
Classification / Educational Major: ____/_____; GPA: _____; Target Graduation Date: _____
# of hours enrolled this semester: _____; History of Scholastic Disciplinary Actions: yes / no __ _____
Disabilities: _____
Employed: yes/no; # of hours/week: _____
Any reprimands/disciplinary actions: yes/no _____
Have you ever been arrested: yes/no _____
Have you ever been the subject of incidents involving the police: yes/no _____
Have you been involved in fist fights since age 15: yes/no _____

FAMILY HISTORY: Have either of your biological parents ever:

Received a diagnosis of mental disease: yes/no _____
Been prescribed anything to stabilize their mood or behavior: yes/no _____
Been admitted to a psychiatric hospital: yes/no _____

PAST MEDICAL HISTORY:

List your ***drug allergies*** and your ***sensitivities*** to drugs, food, latex, tape, etc: _____
Medication History: list all current medications
Prescribed:
Over the counter: _____
Have you ever been prescribed anything to stabilize your mood or behavior: yes/no _____
Habits:
Tobacco: _____ # of cig a day; ____# of years Alcohol: _____ # of drinks/day; _____# days/week
Caffeine _____ # cups/drinks per day Street Drug: _____
Any previous diagnosed medical condition: yes/no _____
Have you had previous psychological treatment: yes/no
Inpatient: _____
Outpatient: _____
Suicidal history:
Have you ever had any suicide attempts: yes/no _____
On a scale of 0 (not at all) to 10, how close have you come to committing suicide _____; when _____
On a scale of 0 (not at all) to 10, how intense are your current thoughts of committing suicide _____
Looking back on your life, what was the most emotionally difficult time for you? _____

CURRENT HISTORY:

Which symptom is causing the biggest problem at this time / how long have you been bothered with this issue?
_____ _____
SLEEP:
Do you typically nap? yes/no _____
Does it take you longer that ½ hour to fall asleep? yes/no; # of times/week: _____; since when? _____;
Do you wake up during the night? yes/no; are you able to go back to sleep? yes/no _____
Are you late or absent for early morning appointments due to staying in bed? yes/no _____
EATING:
Have you (circle) lost or gained approximately 20 pounds? yes/no; since when? _____

Do you (circle) binge / purge / exercise excessively / abuse laxatives / use ipecac / compulsively overeat?

INTEREST:

Is your sex life (check): ___ unchanged; ____increased; ____decreased?

What are you passionate about (what do you enjoy doing)? _____

Have you noticed a change in your enjoyment? yes/no _____

Are you having trouble with keeping up your hygiene / grooming? yes/no _____

Are you withdrawn? yes/no _____

IRRITABILITY:

Are you physically or verbally aggressive to others? yes/no _____

Do you ever feel that you would want to injure someone? yes/no _____

Do you have poor impulse control? yes/no _____

MOOD:

Are you sad? On a scale of 0 (not sad) to 10: _____

Do you cry easily? yes/no; _____

Do you feel hopeless or helpless? yes/no _____

Do you have difficulty concentrating/making decisions? yes/no _____

Do you spend money that you do not have? _____

Do you gamble? yes/no _____

Do you buy items that you do not need? yes/no _____

Have you noticed (circle) increased talking / racing thoughts / increased energy / mood swings _____

Do you have feelings of panic, fear, and uneasiness? yes/no _____

Do you have uncontrollable obsessive thoughts? yes/no _____

Do you have repeated thoughts or flashbacks of traumatic experiences? yes/no _____

Do you have ritualistic behaviors, such as repeated hand washing? yes/no _____

Do you have shortness of breath or rapid heart beat? yes/no _____

Do you have difficulty being still and calm? yes/no _____

Do you have nightmares? yes/no _____

Do you have muscle tension? yes/no _____

Do you feel overwhelmed? yes/no _____

Is there someone that you are certain would drop everything to be by your side if you were ever in a time of need? yes/no.

Name that person: _____ _____

How would that person describe you and your personality?

What emotionally healthy activity do you do when you are feeling down?

Interviewer: _____

Date / results of screenings:

Date / result of diagnostics:

Other pertinent Information:

Comments: