



QUINCY MEDICAL GROUP
Behavioral Health

Date Completed: _____

General History Form

Please complete this form as carefully as you can prior to your visit, print clearly, and bring it with you to your appointment. If you have any questions, please call (217) 222-6550, ext. 3788.

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____

Preferred Name/Nickname: _____

Birthdate: _____ Age: _____ Handedness: Right Left Use both equally

Gender: Male Female Transgender Other/preferred pronouns: _____

Marital Status: Single Married Total # of times _____
 Divorced Separated Widowed Year most recently divorced/separated/widowed: _____

Ethnicity: American Indian Asian Black Hispanic White Other: _____

SOCIAL BACKGROUND

Current Living Situation (alone, with family/friends/roommates - specify # of people/relationships):

Children (amount, gender/ages, proximity to you): _____

Describe Hobbies/Leisure Activities and Typical Daily Activities: _____

Social Support System: Strong Adequate/meets needs Minimal/insufficient, please explain:

Currently Driving: Yes No, explain: _____

Military Service: No Yes, complete the following: Years of Service: ____/____ to ____/____
Branch: Army Navy Air Force Marines Coast Guard National Guard
Discharge Type: _____ Highest Rank: _____
Were you in combat? Yes No
List deployments (country/dates): _____

EDUCATIONAL/VOCATIONAL BACKGROUND

Highest Grade Completed in School: HS Diploma GED Associates Bachelors
 Trade School/Cert Masters Doctorate
 Current Student: _____

If applicable, list degree/date: _____

History of: ADHD or diagnosed learning disability in: Reading Spelling Writing Math
 Received special education or tutoring, explain: _____

Undiagnosed academic weaknesses or particular strengths, explain: _____

Is English your native language? Yes No, began speaking English at age: _____

Years of formal English study: _____

List all languages in which you are currently fluent: _____

Employment Status: Homemaker Retired or Disabled, since: ____/____

Not employed

Other: _____

Employed full-time

Employed part-time

Vocation/Trade: _____ Years in current position: _____

Prior Employment (list types of jobs worked with most recent first and reason you left): _____

LEGAL HISTORY

Current involvement in lawsuits or legal charges? No Yes, describe: _____

Have you been arrested or charged with a crime? No Yes, describe: _____

BEHAVIORAL HEALTH HISTORY

Indicate which of the following statements applies regarding your behavioral health:

I have never been evaluated or treated for a mental or behavioral health concern.

I was treated for a mental or behavioral health concern for the first time at age ____ for:

Depression Anxiety PTSD Bipolar Disorder Schizophrenia

Other: _____

List type (outpatient or inpatient) and date of prior treatment: _____

I am currently in treatment for the following mental or behavioral health concerns:

Depression Anxiety PTSD Bipolar Disorder Schizophrenia

Other: _____

Began Treatment: ____/____ Frequency: Weekly/Biweekly Monthly Other: _____

Treatment Type:

Individual Couples/Family Group Case Manager Medication

Results so far: No change Some benefit Significant benefit Condition worsening

Do you smoke cigarettes: No Yes, amount: _____ per day Quit smoking (date):____/____

Indicate which of the following statements applies regarding your use of alcohol:

- I drink alcohol rarely/never. I have 1-2 drinks/month. I have 1-2 drinks/week.
- I have 2-5 drinks/week. I drink 1-2 drinks/day. I drink several drinks/day.
- I regularly drink until I am drunk. I feel that I have an alcohol problem.
- Prior heavy alcohol drinker for extended period of time; list # of years/date stopped: _____

Do you use cannabis? No Yes, route(s): _____
If yes, frequency: Daily Weekly Socially (describe): _____

Indicate which of the following statements applies regarding your use of illicit substances:

- I have never used illegal substances.
- I previously used recreational drugs for an extended period of time; list: _____
- I currently use (list drug/route/frequency): _____

PHYSICAL HEALTH HISTORY

If known, indicate the following regarding your early development:

- Were there complications during your birth? No Yes, list: _____
- Were you delivered full-term? Yes No, premature by _____ months; birth weight _____
- Were your development milestones on time? Yes No, I was slow learning to:
 Walk Talk Use the toilet
- Did you experience physical/mental/sexual abuse/neglect as a child? No Yes, explain: _____

If known, check all that apply for you and your immediate (blood-related) family:

	Yourself	Children	Parents	Siblings	Grandparents
Diabetes (<input type="checkbox"/> type I <input type="checkbox"/> type II)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low or high thyroid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac concern (heart attack, CABG)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alzheimer's Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parkinson's Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Indicate if you have been diagnosed with or experienced any of the following:

- Deprived of oxygen (e.g. near drowning, suffocated) Autoimmune Disorder
- Epilepsy or seizure disorder Sleep Apnea
- Brain infection (e.g. encephalitis, meningitis) Cancer
- Head injury that resulted in loss of consciousness

If checked any of the above boxes, describe: _____

List any major surgical procedures you have undergone (type/date): _____

Do you use any of the following: Glasses/contacts Hearing aids Walker/cane Wheelchair

CURRENT VISIT INFORMATION

Name of referring physician(s): _____

Primary reason for evaluation (e.g. main concerns): _____

Prior Testing: Brain MRI: Date ____/____ Head CT: Date ____/____ EEG: Date ____/____
 Neuropsychological Testing: Date ____/____
Results, if known: _____

CURRENT SYMPTOMS CHECKLISTS

Have you had any major life changes (e.g. relocation, job change, deaths, medical illnesses, etc) either in the past 1-2 years or around the time that your symptoms began? No Yes, describe: _____

Physical Difficulties (check all that apply): None Blurred/double vision Ringing in ears
 Pain/numbness in the following areas:
 Entire left side or Left Face Left Shoulder Left Arm Left Leg
 Entire right side or Right Face Right Shoulder Right Arm Right Leg
Tremors in: Face Left Hand or Leg Right Hand or Leg Other: _____
Changes in walking: Harder to start moving Slower Pace Smaller Steps Shuffling
 Veering Stumbling Frequent Falls Forward
 Frequent Falls Backward Other: _____

Cognitive Difficulties (check all that apply):

Memory, such as:

- Forgetting:
 - Planned tasks or appointments
 - Names or purpose of medication
 - To take your medication
 - To refill your medication
 - Steps in a recipe
 - To turn off the stove when finished cooking
 - What you planned to buy at the store
 - To lock doors when you leave the house
 - To bring needed items with you when you go from one place to another (e.g. wallet, phone, keys)
 - To perform regular chores (e.g. laundry or garbage removal)
 - The topic of conversation while talking to someone
 - Information others recently told to you or information you read/saw on TV
- Recalling:
 - Day/month/year
 - Where you parked
 - Which direction to turn when exiting a room or building
 - Directions to commonly visited places

- Familiar names
- Meaning of common words
- Losing or misplacing items
- Frequently asking repeat questions or retelling information

Attention, such as:

- Focusing on a task with music or TV on in the background
- Remaining interested in a task for several minutes
- Completing tasks due to feeling restless/unable to sit still
- Watching a TV show for more than 30 minutes
- Moving from task to task without completing prior tasks
- Multitasking (e.g. cooking more than 1 item at the same time)
- Driving, reading signs, following directions, etc. at the same time

Language, such as:

- Thinking of commonly used words or using the wrong word
- Articulating words (e.g. mispronounce words, stutter, etc.)
- Understanding what others are saying to you
- Comprehending instructions or information others provide

Other, such as:

- Slower or more effortful thinking/problem solving
 - Judging correct distances of how far away things are from you
 - Getting lost or difficulty using maps
 - Seeing only parts of objects or mis-perceiving objects
 - Bumping into walls or objects that you didn't realize were there
 - Following sequences or multiple steps in completing a task
 - Starting a task or activity on your own (without reminders)
 - Completing all steps of a task (e.g. paying a bill involves writing a check, recording it in the checkbook, mailing it, etc.)
 - Doing basic math in your head that you used to be able to do
 - Other, describe: _____
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Emotional/Behavioral Difficulties (check all that apply):

- Sadness/depressed mood Anxiety Anger Racing thoughts
 - Acting without thinking things through Social Isolation
 - Decreased interest/pleasure in activities
 - Tears/laughter when you do not feel sad/happy
 - Change in appetite: Decreased Increased Loss of taste Increased cravings for sweets
 - Change in sleep: Decreased Increased Trouble falling asleep Trouble staying asleep
 - Waking early Nightmares Sleep walking Restless legs
 - Appearing to "act out dreams" (as observed by others)
 - Seeing or hearing things that others do not see/hear, describe: _____
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Functional Difficulties completing activities independently (check all that apply):

- Bathing Getting Dressed Using the toilet
- Preparing food Housework (e.g. dishes, laundry)
- Taking medication Grocery shopping Paying bills

Describe assistance: _____

Did symptoms begin: Suddenly, date: ____/____ Gradually

Since symptoms first began, have they: Worsened Stayed the same Gotten better

What do you think has caused your symptoms: _____
