

**Carla Hellekson, MD, PLLC :**

**This form is to save you and your practitioner's time in the interest of providing you with the best service possible. All information on this form is considered confidential. Please answer as carefully and completely as possible.**

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Referred By: \_\_\_\_\_ Phone #: \_\_\_\_\_

***About your current problems***

List the problems of greatest concern to you.

Describe the problems in your own words.

***ANY PRIOR PSYCHIATRIC, SLEEP MEDICINE, OR CHEMICAL DEPENDENCY SERVICES.***

<b>Name of treatment setting; i.e., outpatient/inpatient</b>	<b>Practitioners seen</b>	<b>Dates of Service</b>	<b>Were services helpful?</b>

***SUBSTANCE ABUSE HISTORY***

Have you ever felt you should cut down on your drinking/drug use? Have people annoyed you by criticizing your drinking/drug use? Have you ever felt bad or guilty about your drinking/drug use?

Have you ever drank/used drugs in the morning to steady your nerves or relieve a hangover?

<b>YES</b>	<b>NO</b>

***FAMILY MEDICAL, PSYCHIATRIC AND CHEMICAL DEPENDENCY HISTORY PLEASE NOTE WITH A ( x ) IN THE APPROPRIATE BOX IF THESE CONDITIONS ARE CURRENT OR HAVE OCCURRED IN RELATIVES***

	<b>Children</b>	<b>Siblings</b>	<b>Mother</b>	<b>Father</b>	<b>Uncles/ Aunts</b>	<b>Grandparents</b>	<b>Others</b>
<b>Nervous Problems (anxiety)</b>							
<b>Depression</b>							
<b>Psychiatric Treatment</b>							
<b>Drinking Problems</b>							
<b>Drug Abuse</b>							
<b>Other</b>							
<b>Medical Conditions</b>							
<b>Medical Treatment</b>							

**Adverse / Allergic Drug Reactions:**

<b>Current / Recent Medications:</b>					<b>Primary Care Provider's Name:</b>				
<b>Name:</b>	<b>Dose:</b>	<b>Frequency:</b>	<b>Start</b>	<b>Stop</b>	<b>Name:</b>	<b>Dose:</b>	<b>Frequency:</b>	<b>Start</b>	<b>Stop</b>

Alternative Medications/Vitamins: \_\_\_\_\_  
 Highest weight: \_\_\_\_\_ Current Weight \_\_\_\_\_ Height \_\_\_\_\_ Number of Pregnancies \_\_\_\_\_  
 Regular menstrual periods Yes/ No

Have you had a problem/diagnosis/treatment procedure regarding any of the following? Please check (b) all that apply. Not whether they are current or past problems.

Current	Past	
		Shortness of Breath
		Coughing up blood
		Bleeding from any part of the body
		Chest pain/ palpitation
		Infection
		Stroke
		Sudden loss of Smell, Taste, Vision, Hearing, Sensation
		Convulsions/ Seizures
		Motor coordination/ paralysis
		Sexually transmitted disease
		Frequent severe headaches
		Frequent lingering cough
		Swelling of the hands & feet
		Night sweats/ fevers
		Dizziness/ fainting spells
		Pain in back or extremities
		Jaundice/ hepatitis
		Increased thirst/ urination
		Abdominal pain
		Eating disorder
		Unintentional weight loss/ gain
		Joint/ back problems
		Bleeding mole

Current	Past	
		Asthma
		Thyroid/ gland problems
		High blood pressure
		Diabetes
		Kidney disease/ stones
		Cancer (within last 5 years)
		Arthritis
		Tuberculosis/ exposure
		Heart disease
		Anemia
		Ulcers
		Epilepsy
		Skin problems
		Nutrition problems
		Smoking
		Drugs
		Alcohol
		Hormone replacement therapy
		Other:
		Surgeries/ injuries:

**Family Data:**

**Place of Birth:** \_\_\_\_\_

**Father:** Living or deceased? Age if living: \_\_\_\_\_

Occupation: \_\_\_\_\_

Health status: \_\_\_\_\_

If deceased, cause of death: \_\_\_\_\_

Frequency and nature of contact: \_\_\_\_\_

**Mother:** Living or deceased? Age if living: \_\_\_\_\_

Occupation: \_\_\_\_\_

Health status: \_\_\_\_\_

If deceased, cause of death: \_\_\_\_\_

**Brothers/ Sisters:**

<b>Name</b>	<b>Sex</b>	<b>Age</b>	<b>Resides where?</b>

Did you live with anyone other than your natural parents for any significant time during your childhood years?

***RELATIONSHIP HISTORY***

Marital status:            Single   Married            Divorced            Widowed            Partnered

If married, remarried or partnered, for how long? \_\_\_\_\_

If divorced, separated, or widowed, for how long? \_\_\_\_\_

If previously married or in a long-term relationship, when? \_\_\_\_\_

Spouse/ partner's age: \_\_\_\_\_

Spouse/ partner's occupation: \_\_\_\_\_

Spouse/ partner's prior marriages: \_\_\_\_\_ When?  
How long? \_\_\_\_\_

Children/ stepchildren:

<b>Name</b>	<b>Sex</b>	<b>Age</b>	<b>Resides where?</b>

***EDUCATIONAL HISTORY***

Highest level of education completed \_\_\_\_\_

Did you receive any special educational services? \_\_\_\_\_

***OCCUPATIONAL HISTORY***

Occupation: \_\_\_\_\_ Current position held: \_\_\_\_\_

If not currently working, date you last worked: \_\_\_\_\_

