

MIND HEALTH, P.L.

Lynn M. Williams Psy.D, APRN-IP, PMHNP-BC

Clinical Health Psychologist

Board-Certified Family Psychiatric Nurse Practitioner

2770 Indian River Blvd., Suite 318

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772.231.1379

ADULT INFORMATION FORM

Name _____ Date of 1st Appointment _____ Date of Birth: _____

Therapist _____ Age _____ Gender: Male _____ Female _____

Address: _____ Pharmacy Name and City: _____

Best Telephone Number to reach you: _____ Email: _____

MEDICAL HISTORY

Name of Primary Care Physician: _____

Physician's Address: _____ Physician's Phone: _____

Many managed care companies require that we have interaction with the client's physician to coordinate care. Do you give us consent to discuss your care with the above named doctor? (Circle One) YES NO

Please sign here for either answer: _____

Date of last medical evaluation: _____ Date of next appointment: _____

Current medications being taken:

1) _____ Dosage/Freq _____ Start Date _____ Purpose _____

2) _____ Dosage/Freq _____ Start Date _____ Purpose _____

3) _____ Dosage/Freq _____ Start Date _____ Purpose _____

4) _____ Dosage/Freq _____ Start Date _____ Purpose _____

Prescribed by: _____

Have you ever been hospitalized for medical or psychiatric reasons? (Circle one) YES NO

Hospital	Mo/Yr	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you use recreational drugs? (Circle One) YES NO If no, have you used previously? (Circle One) YES NO

If yes, when did you stop? _____

Type of Drug	How much	How often
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you drink alcohol? (Circle One) YES NO If no, did you drink previously? (Circle one) YES NO

If yes, please list:

Type of Alcohol	How much	How often
_____	_____	_____
_____	_____	_____

Do you smoke cigarettes? (Circle One) YES NO

Do you use other forms of tobacco? (Circle One) YES NO If yes, what kind? _____

Describe any important medical history, chronic ailments, or other health problems you experience: _____

Describe any other health problems or important medical history about your immediate family members and close relatives, including chronic ailments: _____

Do you have any close relatives (father, mother, brother, sister, grandparent) who have experienced depression, anxiety, or other emotional difficulties? Please list: _____

SCHOOL AND FAMILY HISTORY

Did you experience any developmental, academic or behavior problems as a child or while in school, with peers or teachers? (Circle One) YES NO If yes, please explain: _____

What was the last year of school you completed? _____ If you did not complete high school, please explain: _____

Please list schools (1) currently attending, (2) last attended, (3) graduated:

(1) School(s) _____ Year(s) _____
(2) School(s) _____ Year(s) _____
(3) School(s) _____ Year(s) _____

How would you describe your current support network? (friends, relatives, etc.): _____

Please check all information which applies to your biological parents:

MOTHER	<input type="checkbox"/> living	FATHER	<input type="checkbox"/> living
	<input type="checkbox"/> deceased		<input type="checkbox"/> deceased
	<input type="checkbox"/> married		<input type="checkbox"/> married
	<input type="checkbox"/> divorced		<input type="checkbox"/> divorced
	<input type="checkbox"/> remarried _____ # of times		<input type="checkbox"/> remarried _____ # of times

Do you consider someone else (step-parent, grandparent, etc.) to be one or both of your "real" parents? If so, whom? _____

Where do your parents live? Mother _____
Father _____

Describe your relationship with your mother while growing up: _____

Currently: _____

Describe your relationship with your father while growing up: _____

Currently: _____

List first names and ages of brothers & sisters, including yourself:

Name	Age	Relationship (natural, step, half, etc.)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Describe any family problems which occurred while growing up relating to:

Alcohol/drug abuse: _____

Sexual/physical/emotional abuse: _____

MARITAL HISTORY

Marital status: ___Single/never married ___Married ___Separated ___Divorced ___Widowed ___Living w/someone

If currently married, when were you married? _____ If living w/someone, how long? _____

Please list your children:

Name	Age	Relationship (biological/step)	Lives with
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

MENTAL STATUS

Please check any of the following that describe how you have been feeling lately:

___sad ___anxious ___depressed ___frightened ___guilty ___angry ___ashamed ___aggressive ___resentful
___worthless ___tearful ___irritable ___confused ___extreme ups/downs ___jealous ___hopeless ___helpless

Describe any other feelings you have had: _____

What activities or hobbies do you participate in? _____

Do you participate in regular exercise? (Circle One) YES NO Describe: _____

Describe your current working environment: _____

Have you had any change in sleeping habits? (Circle One) YES NO Describe: _____

Have you had any change in eating habits? (Circle One) YES NO Describe: _____

Have you ever **considered suicide** in connection to your **current** problem? (Circle One) YES NO

If so, please give a brief description with dates: _____

Have you ever **considered suicide** in the **past**? (Circle One) YES NO

If so, please give a brief description with dates: _____

Have you **attempted suicide recently** or in the **past**? (Circle One) YES NO

If so, please give a brief description with dates: _____

Have you had any **homicidal thoughts recently** or in regard to your **current** problem? (Circle One) YES NO

If yes, please explain: _____

Have you ever **considered homicide** in the **past**? (Circle One) YES NO

If yes, please explain: _____

LEVEL OF FUNCTIONING

List or describe any current impediments or problems in daily psychological, social or occupational functioning (i.e. isolation from friends/family, significant difficulty getting to work or completing daily tasks, severe financial strain, recent divorce, and problems with supervisor, etc.): _____

THOUGHTS: Please check any of the following that apply to you:

____ I sometimes hear voices even though no one nearby is talking to me.

____ I sometimes feel that forces outside of me control me.

____ I sometimes feel that other people control my thoughts.

____ I sometimes have the same thought over and over and cannot control it.

____ I sometimes feel that someone is out to hurt me or do something against me.

____ I am sometimes unable to control my behavior. Please explain: _____

Is there any other information regarding you or your family that you would like to share with your me that is not covered on this form? You may also use this space to complete earlier responses.

Please list your treatment goals:

Are you involved in any lawsuit or legal issue pertaining to your health? If so, please explain

Have you ever been in a lawsuit for medical or psychiatric reasons and/or do you anticipate filing a legal issue in the future?

Have you ever filed for disability and if not, do you intend to file for disability in the future?

THANK YOU!

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Authorization for Release of Information

I, (print name) _____,

hereby authorize and request the release of written and verbal information for the purpose of coordination of treatment and care to the following persons receiving and/or releasing information:

Name of **Doctor and Specialty** and his/her Office Staff:

Name of Insurance Company: _____

My Insurance Biller and my Bookkeeper (name and number of sessions only) YES ___ NO ___

Other Persons and Your Relationship to Them:

(Name, address and phone number of Party Receiving and/or Releasing Information)

Dr. Lynn Williams, Psy.D, APRN-IP, PMHNP-BC

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Signature of Client: _____ Date: _____

Signature of Guardian (when applicable) _____ Date: _____

Signature of Witness/Therapist: _____ Date: _____