

Siyon Clinical Corporation

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PATIENT INFORMATION

Full Name: _____ DOB: _____

Right / Left Handed _____ WT: _____ HT: _____ Age: _____

Reason for Appointment: _____

Current Pharmacy Name: _____

Address: _____

Phone Number: _____

HEALTH HABITS

Do you currently use any of the following (if yes, how much/how often)?

Caffeine: **Yes / No** _____ Alcohol: **Yes / No** _____

Tobacco: **Yes / No** _____ Marijuana: **Yes / No** _____

Other Illicit Drugs (Ex. Cocaine, Methamphetamine, Opiates, PCP, LSD, Etc.)? **Yes / No** _____

Do you ever blackout? **YES / NO** Describe: _____

Compulsive cleaning? **YES / NO** Describe: _____

Exercise regularly? **YES / NO** Describe: _____

Age of first sexual activity: _____ Pleasant? **Yes / No** Coerced or consensual?

PSYCHIATRIC HISTORY

Have you ever been committed to a psychiatric hospital? **YES / NO** Voluntary / Involuntary

For what reason? _____ How long? _____ Did it help? **YES/NO**

Have you ever gone through an Inpatient Rehab program? **YES / NO** When? _____

Have you ever been in long term therapy? **YES / NO** How long? _____

Name of therapist/psychiatrist/psychologist: _____

MEDICAL CONDITIONS

Any ongoing conditions: Yes / No (circle one)

Please list all ongoing conditions (i.e.; hypothyroid, hypotension, etc.): _____

Allergies to Medications? Yes / No (circle one)

If Yes: Please list medication and symptoms (i.e.; rash, swelling, hives, etc.): _____

MEDICATIONS (CURRENT & PAST)

Current List of Psychiatric Medications (please list on back if more room needed):

Name of Medication	Dosage	Frequency	Diagnosis	How Long?	Side Effects (if any)

Past Psychiatric Medications:

Name of Medication	Dosage	Frequency	Diagnosis	How Long?	Side Effects (if any)

Current list of PAIN or ANY other Medications:

Name of Medication	Dosage	Frequency	Diagnosis	How Long?	Side Effects (if any)

History of Psychiatric Disorder (Family/Self)

Any of these conditions or family history of them? Please check any that apply and whom it affects (self, mother, etc.):

Condition	Self/Relative (specify)	Condition	Self/Relative (specify)
Learning Disability		Dementia	
ADHD		Schizophrenia	
Bipolar		Depression	
Anxiety Disorder(s) such as:		Other (Please Specify)	
OCD		Other (Please Specify)	
Panic Attacks		Other (Please Specify)	
Post-Traumatic Stress		Other (Please Specify)	
Generalized Anxiety		Other (Please Specify)	

Past Psychiatric Care:

Reason	Dates	Type of Treatment/Test	Provider	Hospitalization?

Patient Information and Medical/Mental Health History

Spouse/Partner's first name? _____ How long have you been together? _____
How would you describe your relationship? _____ Is spouse healthy? **YES / NO**
Do you feel you have a strong support system (family/friends)? **YES / NO** Do you have children? **YES / NO**
What are their names and ages? _____
Any children ever seriously ill or hospitalized? **YES / NO** Are they healthy now? **YES / NO**
Children ever been suspended/expelled? **YES / NO** Any legal troubles? **YES / NO**
Is there any family history of (circle all that apply)? Drug Abuse / Arrests / Gang Activity / Domestic
Violence / Suicide Attempts / Overdose / Legal Problems / Lawsuits / Gambling Addiction / Sex Addiction /
Other (please describe if other): _____
Please describe interests (*hobbies, sports, pastimes*): _____

LEGAL HISTORY

Prior Workers' Comp Claims? **YES / NO** Findings: _____
Any other lawsuits? **YES / NO** Describe: _____
Ever been sued? **YES / NO** Ever filed bankruptcy? **YES / NO** Ever been evicted? **YES / NO**
Ever been arrested? **YES / NO** What charges? _____
Ever been convicted? **YES / NO** Ever serve prison/jail time? **YES / NO**
Where/how long? _____
Ever been a victim of a crime? **YES / NO** Describe: _____
Ever been the victim or aggressor of domestic violence? **YES / NO** Describe: _____
Ever lost custody of children? **YES / NO** When? _____ Family or child services involved? **YES / NO**
Other (please specify): _____

Problem Inventory

I am currently experiencing the following problems (check all that apply)

- Relationship problems
- Problems on the job
- Losing someone close to you
- Problems with my children

- Feeling guilty about past mistakes
- Feeling that I am no good
- Feeling the need to get more sleep
- Losing pleasure in daily activities
- Often feeling restless and irritable
- Often feeling sluggish, low energy, or foggy
- Thoughts about dying or killing myself
- Trouble keeping my mind on a task
- Feeling sad

- Preoccupied with sexual thoughts/urges
- Needing less sleep than usual and not feeling tired
- Spending sprees
- Trouble making myself slow down or talk less
- Inflated self-esteem or grandiosity
- Feeling like my thoughts are racing in my head
- Easily distracted

- Fear of crowds or public places,
- Specific fear of a thing or place,
- Attacks of fearfulness when I feel I need to run,
- Heart palpitations,
- Chest pains/discomfort, feeling dizzy or unsteady,
- Feeling things that aren't there,
- Tingling in hands or feet,
- Hot or cold flashes,
- Trouble breathing,
- Feeling shaky or trembling,
- Fears of dying or going crazy,
- Feeling the urge to avoid certain places/objects,
- Feeling troubled by repetitive thoughts,
- Feeling anxious and nervous,
- Worrying about things over and over,

- Feeling the urge to do something unnecessary,
- Checking, hand washing, hair pulling,

- People following me, out to hurt me, talking about me,
- People reading my thoughts,
- Hearing voices,
- Thoughts being put into my head, controlling me, making me do things,
- Special messages to me from TV or radio,

- Feeling emotionally numb,
- Recurring nightmares,
- Frequently feeling startled,
- Being troubled by painful memories,
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- Parts of my body not functioning well,
- Feeling aches and pains all over my body,
- Often feeling sickly,
- Fear of having or getting a disease
- Problems with my memory,
- Knowing where or who I am,
- Getting lost or confused,
- Having trouble remembering my past,
- Finding things,
- Feeling that I've lost time,

- Urges to do something harmful to myself,
- Urges to set fires,
- Difficulty controlling my temper,
- Feeling anger or resentment,

- Taking laxatives to control my weight,
- Vomiting to control my caloric intake,
- Exercising frequently and vigorously,
- Fasting in order to control my weight,
- Feeling helpless about my eating habits,
- Extreme changes in my weight.

By signing below, I certify that the information on this form is true and correct:

Signature: _____ **Date:** _____

Print name: _____