Siyan 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: Select C _____ Alcohol: Select C _____

Tobacco: Select C _____ Marijuana: Select C _____

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

Do you ever blackout? Select One Describe: _____

Compulsive cleaning? Select One Describe: _____

Exercise regularly? Select One Describe: _____

Age of first sexual activity: _____ Pleasant? Select One Coerced or consensual?

PSYCHIATRIC HISTORY

Have you ever been committed to a psychiatric hospital? Select One Select One

For what reason? _____ How long? _____ Did it help? Select One

Have you ever gone through an Inpatient Rehab program? Select One When? _____

Have you ever been in long term therapy? Select One How long? _____

Name of therapist/psychiatrist/psychologist: _____

MEDICAL CONDITIONS

Any ongoing conditions: Select One

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

_____

_____

Allergies to Medications? Select 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?

TYPES OF TREATMENT (circle applicable)	Y/N		HOW HELPFUL WAS TREATMENT		
Acupuncture:	☐ Yes	☐ No	☐ No Help	☐ Good	☐ Very Helpful
Physical Therapy:	☐ Yes	☐ No	☐ No Help	☐ Good	☐ Very Helpful
Chiropractic:	☐ Yes	☐ No	☐ No Help	☐ Good	☐ Very Helpful
Injections:	☐ Yes	☐ No	☐ No Help	☐ Good	☐ Very Helpful
Type:	☐ Epidural	☐ Cortisone	☐ No Help	☐ Good	☐ Very Helpful

Surgery: Select One If yes, list body part(s) and Date: _____

MRI: Select One If yes, list body part(s) and Date: _____

EMG: Select One If yes, list Date: _____

Do you have any of the following (please circle yes or no):

Tuberculosis ☐ Yes ☐ No Hepatitis ☐ Yes ☐ No High Cholesterol ☐ Yes ☐ No

HIV ☐ Yes ☐ No Diabetes ☐ Yes ☐ No

Heart Disease ☐ Yes ☐ No High Blood Pressure ☐ Yes ☐ No

Other serious illnesses: _____

Women's Gynecologic History

#of Pregnancies: ____ # of Births: _____ # of C-Section Deliveries _____ # of Abortions: _____

1st day of last period: _____ Age of 1st period: _____ Frequency: _____ Duration: _____

Do you have any concerns about your periods? Select One Concerns about menopause? Select One

Abuse History

Are/Were you a victim of any of the following abuses?

Physical Abuse: Select One Age(s) of occurrence: _____

Sexual Abuse: Select One Age(s) of occurrence: _____

Emotional Abuse: Select One Age(s) of occurrence: _____

SOCIAL HISTORY

Where were you born? _____ Where did you grow up? _____

Siblings: ___# of Brothers __# of Sisters

Have any siblings died? Select One When? _____ Are living siblings in good health? Select One

Were there any complications at your birth (premature, major medical problems)? Select One

If yes, please describe: _____

Were there any problems in your early development (learning to walk, talk, etc.)? Select One

If yes, please describe: _____

Did you suffer from any major illnesses/injuries while growing up? Select One

If yes, please describe: _____

Are you currently involved in a romantic relationship? Select One

Spouse/Partner's first name? _____ How long have you been together? _____

How would you describe your relationship? _____ Is spouse healthy? Select One

Do you feel you have a strong support system (family/friends)? Select One Do you have children? Select One

What are their names and ages? _____

Any children ever seriously ill or hospitalized? Select One Are they healthy now? Select One

Children ever been suspended/expelled? Select One Any legal troubles? Select One

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? Select On Findings: _____

Any other lawsuits? Select On Describe: _____

Ever been sued? Select One Ever filed bankruptcy? Select One Ever been evicted? Select One

Ever been arrested? Select One What charges? _____

Ever been convicted? Select One Ever serve prison/jail time? Select One

Where/how long? _____

Ever been a victim of a crime? Select On Describe: _____

Ever been the victim or aggressor of domestic violence? Select On Describe: _____

Ever lost custody of children? Select Or When? _____ Family or child services involved? Select One

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,
- ☐
- ☐ 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: _____