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. 3980.

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: _____

Select all that apply: ☐ 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 <u>currently</u> 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 use nicotine: ☐ No ☐ Yes, amount: _____ per day ☐ Quit (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 (☐ type I ☐ type II)	☐	☐	☐	☐	☐
Low or high thyroid	☐	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Cardiac concern (heart attack, CABG)	☐	☐	☐	☐	☐
Alzheimer's Disease	☐	☐	☐	☐	☐
Parkinson's Disease	☐	☐	☐	☐	☐

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 neuropsychological evaluation (e.g. types of cognitive/thinking difficulties; related medical condition or injury): _____

_____

Date of onset or diagnosis of primary condition: _____

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

**If you have or can obtain a copy of a prior neuropsychological report, please bring it with you to your appointment.*

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):
Attention, such as:
☐ Focusing on a task with music or TV on in the background
☐ Remaining interested in a task for several minutes
☐ Remaining interested in a task for several hours
☐ Completing tasks due to frustration
☐ 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 <u>at the same time</u>)
☐ Driving, attending to other drivers or pedestrians on the road, reading road signs, following directions, etc. <u>at the same time</u>
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

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
  - ☐ 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 existing a room or building
  - ☐ Directions to commonly visited places
  - ☐ Familiar names
- ☐ Losing or misplacing items
- ☐ Frequently asking repeat questions or retelling information

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)
- ☐ Doing basic math in your head that you used to be able to do
- ☐ Other, describe: _____

_____

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: _____

_____

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: _____