Behavioral Health Care Associates

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Schaumburg, IL 60194

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Specialists in Psychiatry, Substance Abuse and Counseling

Medical History

Welcome to Behavioral Health Care Associates. Please fill out this form completely and accurately so that we may better assist you in your treatment. **All responses are confidential.**

Patient Name_____Today's Date_____

Gender: M F Date of Birth_____/_____/_____ SS#_____

Email_____Home #(_____)_____ Cell #(_____)_____

Address_____City_____ZIP_____

Demographics (Confidential): Ethnicity_____Preferred Language (If not English)_____

Parent/Guardian's Name (If patient is a minor)_____

Employer_____Occupation_____

Family / Primary Care Doctor_____Ph #(_____)_____

Name of Insurance Subscriber_____ Relation_____

Gender: M F Date of Birth_____/_____/_____ SS#_____

Name of Insurance Carrier_____Group #_____

ID #_____If Applicable: [Site Name_____Site#_____]

Reason for your appointment / chief complaint: _____

Is the condition due to a work related Injury? ☐ Yes ☐ No Is the condition due to an auto accident? ☐ Yes ☐ No

If you answered yes, to any of the above questions, please note that we DO NOT accept Worker's Compensation or any auto insurance, except payment made in full at the time of service.

Date of last physical examination _____ Where was that done?_____

Date of EKG _____ Where was that done?_____

Drug allergies: Please do not list seasonal or food allergies here. □ **Check here if you have no known drug allergies.**

Drug Name	Reaction Type	Severity (Mild, Moderate, Severe)

Medications: Prescription and non-prescription medications, inhalers, birth control, vitamins, and supplements

Medication Name	Dose	Frequency

Have you experienced any of the following symptoms? Please check **ALL** that apply.

Constitutional		Cardiovascular		HEENT		Hematology / Lymphatic	
Weight loss	□	Chest pain	□	Headache	□	Anemia	□
Weight gain	□	Irregular heartbeat	□	Vision loss / eye pain	□	Bleeding issues	□
Poor appetite	□	Elevated blood pressure	□	Dry eyes / irritation	□	Low blood count	□
Binging	□	Heart disease	□	Decreased hearing / ear pain	□	Easy bruising	□
Fever	□	Shortness of breath	□	Sinus pain	□	Swollen lymph nodes	□
Night sweats / chills	□	Swelling of limbs	□	Hoarseness	□	Transfusions	□
Fatigue / no energy	□	Genitourinary		Sore throat	□	Endocrine	
Insomnia	□	Frequent urination	□	Trouble swallowing	□	Goiter	□
Memory loss	□	Urinary retention	□	Respiratory		Heat intolerance	□
Gastrointestinal		Frequent UTIs	□	Chronic cough	□	Cold intolerance	□
Abdominal pain	□	Pain urinating	□	Wheezing	□	Increased thirst	□
Bloody stool	□	Blood in urine	□	Shortness of breath	□	Change in skin pigment	□
Constipation	□	Incontinence	□	Coughing up blood	□	Excess sweating	□
Diarrhea	□	Menstrual irregularities	□	Excess sputum production	□	Allergic / Immune	
Frequent heartburn	□	Endocrinology		Skin		Hay fever	□
Jaundice	□	Diabetes	□	Rash	□	Frequent infections	□
Kidney stones	□	Excessive thirst	□	Hives	□	Hepatitis	□
Nausea	□	Excessive / painful urination	□	Skin sores / ulcers	□	HIV positive	□
Vomiting	□	Libido change	□	Eczema	□	Positive TB/PPD skin test	□
Neuro / Psychiatric							
Blackouts	□	Euphoria	□	Tremors / tics	□	Compulsive behavior	□
Dizziness	□	Loss of interest	□	Violent behavior	□	Panic attacks	□
Seizures	□	Increased sexual activity	□	Not attending school / work	□	Suicidal thoughts	□
Stroke	□	Loneliness	□	Cruelty to animals / people	□	Irritability / agitation	□
Sleep issues	□	Paranoia	□	Anxiety	□	Alcohol dependence	□
Hallucinations/ delusions	□	Poor concentration	□	Depression	□	Illicit drug dependence	□
Crying spells	□	Poor memory	□	Mood swings	□	Opioid drug dependence	□

Operations: _____

_____

Hospitalizations: _____

_____

Previous Mental Health Diagnosis:

_____

Who is your Primary Physician?_____

Have you experienced any losses in the last 2 years? ☐ Yes ☐ No

If yes, whom/when? _____

What is your current support system? _____

Have you ever had Suicidal Thoughts? ☐ Yes ☐ No

If yes, how often? ☐ Occasionally ☐ Frequently

If yes, do you have a plan? ☐ Yes ☐ No

If yes, do you have the means? ☐ Yes ☐ No

Have you ever attempted Suicide? ☐ Yes ☐ No # of times _____

If yes, when and how was the last attempt made? _____

Have you ever had thoughts of harming others? ☐ Never ☐ Occasionally ☐ Frequently

Have you ever been arrested? ☐ Yes ☐ No # of times_____

Have you in the past or do you currently smoke tobacco? ☐ Yes ☐ No

If yes, how much per day? _____ Date of Last Use? _____

When consuming alcohol, do you typically have?

☐ 1 to 2 drinks ☐ 3 to 4 drinks ☐ 5 to 6 drinks ☐ 7 to 8 drinks ☐ 9 or more

How often do you consume alcohol? ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly

Have you ever experienced DTs after you had stopped drinking? ☐ Yes ☐ No

Have you ever illegally missed your prescription medications or used illegal drugs? ☐ Yes ☐ No

If yes, What/When/How? _____

If yes, Date of Last Use? _____

If yes, Frequency of Use? _____

Is there a family history of Mental Illness? ☐ Yes ☐ No

If yes, Who was it?
☐ Your father ☐ Your mother ☐ Your brother
☐ Your sister ☐ Your Grandfather ☐ Your Grandmother ☐ Your step-father
☐ Your step-mother ☐ Children ☐ Aunt/Uncle ☐ Cousins

If yes, What did they suffer from? _____

Is there a family history of Substance Abuse / Alcoholism? ☐ Yes ☐ No

If yes, Who was it?
☐ Your father ☐ Your mother ☐ Your brother
☐ Your sister ☐ Your Grandfather ☐ Your Grandmother ☐ Your step-father
☐ Your step-mother ☐ Children ☐ Aunt/Uncle ☐ Cousins

If yes, What did they suffer from? _____

Have you ever been Abused? ☐ Yes ☐ No

If yes, was it: ☐ Physical ☐ Emotional ☐ Sexual

How many Close Friends do you have?_____ How often do you see them?_____

What are the names and ages of your spouse and/or children?_____

_____

Who do you live with? (Check all that apply.)

☐ Parents ☐ Spouse ☐ Children ☐ Significant Other ☐ Alone ☐ With Roommates

Employment Status? ☐ Employed Full-time (Over 32 hours) ☐ Employed Part time
☐ Unemployed ☐ Other: _____

Line of Work? _____

What is your highest level of Education?_____

What is your Religion?_____

Have you ever been diagnosed with?

Check YES or NO…

Ulcers?	☐ Yes	☐ No	Cancer?	☐ Yes	☐ No
Diabetes?	☐ Yes	☐ No	Stroke?	☐ Yes	☐ No
Seizures?	☐ Yes	☐ No	Migraines?	☐ Yes	☐ No
Bronchitis?	☐ Yes	☐ No	Tuberculosis?	☐ Yes	☐ No
Osteoporosis?	☐ Yes	☐ No	Osteoarthritis?	☐ Yes	☐ No
Heart Disease?	☐ Yes	☐ No	Kidney disease?	☐ Yes	☐ No
Rheumatic Fever?	☐ Yes	☐ No	Thyroid problems?	☐ Yes	☐ No
Allergies/ Asthma?	☐ Yes	☐ No	Immune Deficiency?	☐ Yes	☐ No
Rheumatoid Arthritis?	☐ Yes	☐ No	High Blood Pressure?	☐ Yes	☐ No
Angina/ Chest Pain?	☐ Yes	☐ No	Sexually Transmitted Disease?	☐ Yes	☐ No
Other: _____	☐ Yes	☐ No	Other: _____	☐ Yes	☐ No

Females Only

Are you currently pregnant? ☐ Yes ☐ No Date of Last Menstrual Cycle? _____

Are you currently on Birth Control? ☐ Yes ☐ No

Have you ever been pregnant? ☐ Yes ☐ No If yes, How many times? _____

If yes, What was the outcome of the pregnancy (s)? _____

For Children - Developmental Milestones

At one month did your child cry to communicate and/or have eye contact? ☐Yes ☐No

At four months could your child turn from their back to their abdomen, lift their head, grasps with both hands, and laugh? ☐Yes ☐No

At 7 months was your child able to crawl and bear weight on feet when supported? ☐Yes ☐No

At 9 months was your child able to walk along side furniture, crawl well, bang objects together, drink from a cup, and attempt to feed themselves? ☐Yes ☐No

At 11 months was your child able to understand the meaning of words, shook their head to say "No" follow simple directions, cooperate with dressing activities and use a spoon? ☐Yes ☐No

For Adolescents

Did you ever runaway? ☐ Yes ☐ No # of times:_____

What grade are you in school?_____ What are your grades in School?_____

Have you experienced any of the following in the last Six Months? If yes, Please check the appropriate Box(s).

Mood

- ☐ Normal
- ☐ Depressed Mood
- ☐ Euphoric Mood
- ☐ Mood Shifts/Swings
- ☐ Fearfulness
- ☐ Compulsive Behavior
- ☐ Panic Attacks
- ☐ Afraid of Travel
- ☐ Restless/Overactive
- ☐ Crying spells
- ☐ Feeling Guilty
- ☐ Anxious Mood
- ☐ Irritable
- ☐ Short-tempered
- ☐ Fear of Crowds
- ☐ Fear of being alone
- ☐ Fear of Public Speaking
- ☐ Increase in social activity
- ☐ Loss of interest in activities
- ☐ Decrease in energy; fatigue
- ☐ Increase in sexual activity
- ☐ Persistent emptiness & boredom
- ☐ Increase in occupational activity

Concentration

- ☐ Normal
- ☐ Attention Span Short
- ☐ Bizarre Thoughts
- ☐ Delusions
- ☐ Thoughts too fast
- ☐ Indecisiveness
- ☐ Poor Memory
- ☐ Paranoid
- ☐ Hallucinations
- ☐ Obsessive thoughts
- ☐ Thoughts too slow
- ☐ Easily Distracted
- ☐ Poor concentration

Appetite

- ☐ Normal
- ☐ Weight change
- ☐ Binging
- ☐ Craving Sweets
- ☐ Decreased appetite
- ☐ Vomiting
- ☐ Increased appetite

Behavior/Motor

- ☐ Normal
- ☐ Socially withdrawn
- ☐ Argumentative
- ☐ Tremors/Tics
- ☐ Agitated Behavior
- ☐ Speech Disturbances
- ☐ Criminal activity
- ☐ Self-Destructive Behavior
- ☐ Neglect hobbies
- ☐ Truancy
- ☐ Repetitious Behavior
- ☐ Aggression/Rage
- ☐ Violent behavior
- ☐ Running away
- ☐ Not attending school/work
- ☐ Cruelty to animals/people
- ☐ Destructive to others or property
- ☐ Impulsive Behavior / Speech

Interpersonal / Social Characteristics

- ☐ Unstable and intense relationships
- ☐ Self-centered
- ☐ No close friends or confidants
- ☐ Perfectionist
- ☐ Expects to be exploited or harmed by others
- ☐ Procrastinates
- ☐ Interpersonal exploitive ness
- ☐ Indifferent to feelings of others
- ☐ Chooses relationships that lead to disappointment
- ☐ Excessive devotion to work
- ☐ Inability to sustain consistent work
- ☐ Avoids significant interpersonal contacts
- ☐ Constantly seeking praise or admiration

Substance Abuse

- ☐ Yes ☐ No During the last year, have you had a feeling of guilt or remorse after drinking?
- ☐ Yes ☐ No During the last year, have you failed to do what was normally expected from you because of drinking?
- ☐ Yes ☐ No During the last year, has a friend or a family member ever told you about things you said or did while you were drinking that you could not remember?
- ☐ Yes ☐ No Do you sometime take a drink when you first get up in the morning?
- ☐ Yes ☐ No Can you get through the week without using drugs?
- ☐ Yes ☐ No Are you always able to stop using drugs when you want to?
- ☐ Yes ☐ No Do you ever feel bad or guilty about your drug use?
- ☐ Yes ☐ No Does your spouse (or parents) ever complain about your involvement with drug

I certify that the above is true, accurate and complete to the best of my knowledge and that my treatment plan may be influenced by what I have written to omitted. I agree to inform my clinicians of any future changes or updates to my condition.

Signature: _____ Date: _____