PALOUSE PSYCHIATRY & BEHAVIORAL HEALTH

PULLMAN REGIONAL HOSPITAL CLINIC NETWORK

Welcome to our clinic!

Attached are the registration documents that we will need for you to complete and bring with you to your appointment.

It is required that you show up 15 minutes early for your appointment. If paperwork is not completed, or you are unable to arrive early, your appointment may need to be rescheduled.

Our office is located in the Corporate Point Building (on the 2nd floor), across the street from Pullman Regional Hospital and next to Zeppoz.

Thank you and we look forward to seeing you.
Psychiatry & Behavioral Health
840 SE Bishop Blvd., #203
Pullman, WA 99163
509-339-2394 (Phone)
509-336-7484 (Fax)

PALOUSE PSYCHIATRY & BEHAVIORAL HEALTH
PULLMAN REGIONAL HOSPITAL CLINIC NETWORK

HEALTH HISTORY

Primary Care Physician: _____ Primary Care Physician Phone #: _____

Who referred you to us? _____ Date of Last Complete Check-Up: _____

What are the primary concerns you are wanting to address?_____

_____

_____

Are you currently taking any medication? ☐ No ☐ Yes

Please list all medications, including herbal supplements/over the counter drugs:

Name of Medication:	Dose:	Purpose:	Effect:	Prescribing Provider:

MEDICAL HISTORY

Have you ever experienced serious illness, injury, or hospitalization, or do you have any physical disabilities?
☐ No ☐ Yes Describe: _____

_____

_____

Have you experienced any of the following?
☐ Head injuries Describe: _____
☐ Seizures Describe: _____
☐ Abnormal motor twitches Describe: _____

Have you had any difficulties with:
Eating? ☐ No ☐ Yes – Describe: _____
Speaking? ☐ No ☐ Yes– Describe: _____
Menstruating? ☐ No ☐ Yes– Describe: _____

Current Substance Use
☐ Alcohol: _____ drinks, _____ times per week.
☐ Tobacco: (cigarettes, chewing tobacco, vaporizer), _____ (amount) daily, for _____ years.
☐ Caffeine: _____ cups per day, _____ times per week.
☐ Other Substance use:

PATIENT/FAMILY HISTORY

	Patient	Family Member(s)
Adverse Reaction to Anesthesia		
Allergies (dust, pollen, pets, foods)		
Anemia		
Asthma		
Atherosclerosis		
Autoimmune Disorder		
Cancer of the Breast		
Colon Cancer		
Congenital Anomaly		
Coronary Artery Disease		
Dementia		
Diabetes		
Eczema		
Genetic Disorder		
Glaucoma		
Heart Attack		
High Blood Pressure		
Huntington's Disease		
Hyperlipidemia		
Kidney Disease		
Lung Cancer		
Malignant Hyperthermia		
Migraines		
Mild Cognitive Impairment (MCI)		
Multiple Sclerosis		
Obesity		
Osteoporosis		
Other Blood Disorder		
Other Cancer		
Ovarian Cancer		
Parkinson's Disease		
Prostate Cancer		
Rheumatoid Arthritis		
Seizures		
Skin Cancer		
Strokes		
Thyroid Disease		
Tobacco Abuse		
Tuberculosis		

KEY

M: Mother F: Father
S: Sister B: Brother
Son: Son Dau: Daughter
PGF: Paternal Grandfather
PGM: Paternal Grandmother
MGF: Maternal Grandfather
MGM: Maternal Grandmother
A: Aunt U: Uncle C: Cousin

Any other health conditions not listed?

Sleep

Have you had any difficulties with sleeping? ☐ No ☐ Yes – Describe:

_____

Do you experience problems falling asleep? ☐ No ☐ Yes – Describe: _____

_____

Do you experience problems staying asleep? ☐ No ☐ Yes – Describe: _____

_____

Any history of parasomnias (e.g. sleepwalking, night terrors, etc.)? ☐ No ☐ Yes – Describe: _____

_____

Have you ever completed a sleep study? ☐ No ☐ Yes – Describe: _____

_____

Do you nap? ☐ No ☐ Yes – Describe: _____

Sleep / Wake Schedule: _____

Average hours of sleep per night: _____

Number of hours that would be ideal: _____

Suicide Risk Assessment

Have you ever had feelings or thoughts that you didn't want to live? ☐ No ☐ Yes

➔ *If YES, please answer the following. If NO, please skip to the next section.*

Do you currently feel that you don't want to live? ☐ Yes ☐ No

How often do you have these thoughts? _____

When was the last time you had thoughts of dying? _____

Has anything happened recently to make you feel this way? _____

_____

On a scale of 1 to 10 (10 being strongest), how strong is your desire to kill yourself currently? _____

Would anything make it better? _____

Have you ever thought about how you would kill yourself? _____

Is the method you would use readily available? _____

Have you planned a time for this? _____

Is there anything that would stop you from killing yourself? _____

Do you feel hopeless and/or worthless? _____

Have you ever tried to kill or harm yourself before? _____

On a scale from 0 to 100 (100 being full confidence), how confident are you that you will be able to keep yourself safe currently? _____

Have you ever received a mental health diagnosis or treatment previously? ☐ No ☐ Yes

If yes, where? _____

_____

Have you ever completed a psychiatric inpatient stay? ☐ No ☐ Yes

If yes, please describe: _____

_____

_____

Is there any other relevant information you would like to provide us? ☐ No ☐ Yes

If yes, please describe: _____

_____

PSYCHIATRIC HISTORY

Current Symptoms Checklist: (check once for any symptoms present, circle for major symptoms)

- ☐ Depressed mood
- ☐ Unable to enjoy activities
- ☐ Sleep pattern disturbance
- ☐ Loss of interest
- ☐ Concentration/forgetfulness
- ☐ Change in appetite
- ☐ Excessive guilt
- ☐ Fatigue
- ☐ Decreased libido
- ☐ Racing thoughts
- ☐ Impulsivity
- ☐ Increased risky behavior
- ☐ Increased libido
- ☐ Decreased need for sleep
- ☐ Excessive energy
- ☐ Increased irritability
- ☐ Crying spells
- ☐ Indecisiveness
- ☐ Excessive worry
- ☐ Panic attacks
- ☐ Avoidance
- ☐ Hallucinations
- ☐ Suspiciousness
- ☐ Dissociation
- ☐ _____
- ☐ _____
- ☐ _____

PATIENT/FAMILY PSYCHIATRIC HISTORY

	Patient	Family Member(s)
Anxiety		
Attention Deficit /Hyperactivity Disorder		
Autism Spectrum Disorder		
Bipolar Disorder		
Depression		
Hoarding Disorder		
Intellectual Disability		
Learning Difficulties/SLD		
Obsessive-Compulsive Disorder		
Personality Disorder		
Post-Traumatic Stress Disorder		
Schizophrenia		
Suicidal Behavior/Ideation		
Violent Behavior/Ideation		
Other:		

KEY

M: Mother F: Father
S: Sister B: Brother
Son: Son Dau: Daughter
PGF: Paternal Grandfather
PGM: Paternal Grandmother
MGF: Maternal Grandfather
MGM: Maternal Grandmother
A: Aunt U: Uncle C: Cousin

If anyone has been diagnosed with any of the above mental health disorders, please list the diagnosis and whether or not treatment has been received, including medication:

Diagnosis:	Treatment Received:	Medications:

DEVELOPMENTAL HISTORY

Were alcohol, drugs or tobacco used during your mother's pregnancy? ☐ No ☐ Yes (If yes, see below.)

a. Which substance(s)? _____
b. Quantity and frequency? _____
c. How long/Still currently using? _____

Did your mother experience any high stress levels or illness during pregnancy? ☐ No ☐ Yes
(If yes, please describe the illness and any treatment, medication or special diet your mother received.)_____
_____

Where were you born? _____
Were you born prematurely? ☐ No ☐ Yes If yes, number of weeks: _____
How long did labor last? _____ Birth Weight: _____

How were you born? ☐ Head first ☐ Feet first ☐ Breech (buttocks first) ☐ C-Section ☐ Other_____

Were there any difficulties or peculiarities in your appearance or behavior at birth or during infancy?
☐ No ☐ Yes If yes, describe: _____

Were you given oxygen? ☐ No ☐ Yes -If yes, for how long? _____
Blood transfusions? ☐ No ☐ Yes
Placed in an incubator? ☐ No ☐ Yes -If yes, for how long? _____
Other medical treatment? ☐ No ☐ Yes - Describe: _____

INFANCY & NEWBORN

By whom were you raised? _____
Looking back on your early childhood years, and based on what you have been told by others, were you:
(Check any that apply.)

- ☐ Difficult to Sooth
- ☐ Easy-Going
- ☐ Slow to Warm

Please describe: _____
_____

Did you experience any developmental delays or problems? ☐ No ☐ Yes

Describe: _____
_____
_____

At what age did you first smile? _____ Walk alone? _____
Say your first word? _____ Speak in sentences? _____
At what age was bowel training complete? _____ Urinary training? _____
Was there any difficulty in training? ☐ No ☐ Yes - Describe: _____
Any past or present problems in bowel or urinary control? ☐ No ☐ Yes - Describe: _____
_____

EARLY CHILDHOOD

Did you experience any difficulties with expressing your emotions in childhood? ☐ No ☐ Yes
Describe: _____

Did it take a long time for you to warm up to new situations or new people? ☐ No ☐ Yes
Describe: _____

Did you react *strongly/not at all* to physical pain? ☐ No ☐ Yes
(circle one, if applicable)
Describe: _____

Did you react strongly to other things? ☐ No ☐ Yes Explain: _____

EARLY SOCIALIZATION:

Describe your early socialization skills with others within and outside the home: _____
_____
_____

What parenting strategy/style was implemented at home (i.e. Time-Out, Positive Reinforcement, etc.)
Describe: _____
_____
_____

EDUCATIONAL AND CULTURAL HISTORY

What is your primary language?: _____

What is your cultural or ethnic background?: _____

What is the highest grade you completed in school?: _____

- ➔ What was your GPA when you graduated from high school?: _____

Have you completed any additional degrees (e.g. A.A., B.S., Master's, PhD, MD, etc.)? ☐ No ☐ Yes
If yes, please describe: _____
_____

- ➔ What was your GPA in college?: _____
- ➔ What was your GPA in graduate school?: _____

Any history of disciplinary action in school?: ☐ No ☐ Yes
If yes, please describe: _____
_____
_____

CURRENT SOCIAL HISTORY

List all individuals currently living with you. Specify relationship (e.g. spouse, friend, sibling [full, half, step, foster], other)

First & Last Name	Sex	Age	School Grade / Occupation	Relationship to Patient

Any significant life transitions within the home or environment? ☐ No ☐ Yes
If yes, please describe: _____

Are you currently involved in any litigation? ☐ No ☐ Yes
If yes, please describe: _____

Do any of the following problems apply to your current living situation?

Marital or relationship problems	☐ No ☐ Yes
Problems with other persons living at home	☐ No ☐ Yes
Problems with present living situation/housing	☐ No ☐ Yes
Recent major changes or stressors in the living situation or family	☐ No ☐ Yes
Violence in the home or neighborhood	☐ No ☐ Yes
Alcohol or drug problems in the home or neighborhood	☐ No ☐ Yes
Other problems, such as legal issues, financial strain, etc.	☐ No ☐ Yes

If yes to any of the above, please describe:

_____

_____

Please describe your typical day:

_____

_____

What sorts of hobbies do you enjoy? _____

Are there any other factors in your current social/living situation that you would like to discuss?

_____

_____

_____