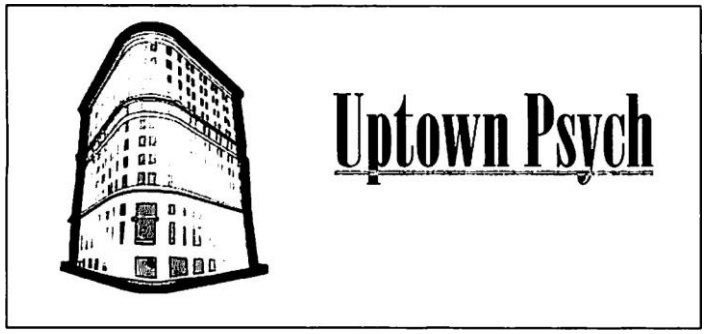


4753 N. Broadway St. Suite 910
Chicago, IL. 60640
Phone: 773-989-2780
Fax: 773-989-2781 info@uptownpsych.com www.uptownpsych.com

# PSYCHIATRY HEALTH HISTORY FORM

Date:

Name

Reason for visit today:

Past Medical History:

Current medical conditions:

Current medications:

Allergies:

Past Psychiatric History:

History: History of counseling/therapy: (Indicate when, where, name of counselor)

Previous trials of psychiatric medications:

Previous psychiatric hospitalization: (Indicate when and where)

## PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

| Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use "V" to indicate your answer) | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|
| 1. Little interest or pleasure in doing things | | 1 ☐ | 2 ☐ | 3 ☐ |
| 2. Feeling down, depressed, or hopeless | | 1 ☐ | 2 ☐ | 3 ☐ |
| 3. Trouble falling or staying asleep, or sleeping too much | | 1 ☑ | 2 ☑ | 3 ☐ |
| 4. Feeling tired or having little energy | | 1 ☑ | 2 ☑ | 3 ☑ |
| 5. Poor appetite or overeating | | 1 ☑ | 2 ☑ | 3 ☑ |
| 6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down | | | 2 ☑ | 3 ☑ |
| 7. Trouble concentrating on things, such as reading the newspaper or watching television | | | 2 ☑ | 3 ☑ |
| 8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual | | 1 ☑ | 2 ☑ | 3 ☑ |
| 9. Thoughts that you would be better off dead or of hurting yourself in some way | | 1 ☑ | 2 ☑ | 3 ☑ |

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

◯ Not difficult ◯ Somewhat difficult ◯ Very difficult ◯ Extremely difficult