

		Patient's Name: DOB: Date: Person Filling Form:		
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6.	Do you (the patient) currently use <u>SUBSTANCES</u> or have in the past used any substances. Please also list you have ever been habituated to or addicted to any medication/prescription drug or street drugs. Have yo ever been in any Chemical dependency treatment setting (either inpatient or outpatient)?
7.	Please provide the name of your(the patient's) <u>PRIMARY CARE PHYSICIAN</u> (primary prescribing nurse practitioner). When was your most recent physical examination? When was the last time you had a lab examination?
8.	Do you (the patient) have any <u>ALLERGIES TO MEDICATIONS</u> ? environmental agents or any othe agents? If yes please give us a detailed list of all known agents that you are allergic to.
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www.PugeiSoundPsychiatricCenter.org Patient's Name: DOB: Date: Person Filling Form: 9. Do you (the patient) have any CURRENT AND ACTIVE MEDICAL PROBLEMS? If yes please give all details possible, including when diagnosed, current treatment etc. 10. Have you (the patient) ever had any PREVIOUS MEDICAL CONCENRNS that no longer need treatment or monitoring? Please give details of the conditions and how treated and cured? 11. Is there a FAMILY HISTORY OF PSYCHIATRIC ILLNESSES, please describe any psychiatric conditions exist biological maternal and paternal families. Please also describe if there is any history of substance use or abuse in the family. Any history of suicidal gestures, attempts or completion should also be listed.



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		AN ACTION AND PROPERTY OF THE	是在4月份的企业的,4位至2月以下的大型企业。第二日的大型。40°00000000000000000000000000000000000
12. Is there a FAMIL	Y HISTORY OF MEDICA	AL PROBLEMS in either you	r maternal or paternal family?
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	2	Washing Server	
14. Please describe if yo	ou (the Patient's) have ever b	een in any <u>LEGAL PROBL</u>	EMS (if applicable).



www.PugetSoundPsychiatricCenter.org Patient's Name: DOB: Date: Person Filling Form: 15. Please describe your (The Patient's) EDUCATION AND OCCUPATION (as applicable); please give details if schooling has been or is a problem; or if you are experiencing problems in your occupation. 16. Please describe your (The Patient's) SOCIAL HISTORY such as your current housing/living situation, and relationships. Please include an account of your immediate family, parents, siblings and children (as applicable); please also give an account of social supports, friends, significant relationships etc. 17. Please tell us if there are other concerns that are important to you that have not been addressed in the questions above.

PIHCR Symptom Questionnaire & Tracking Form (PSQ 50 TF)

Patients Name:		
Date:	Date Of Birth:	
Name and Relationship of Person Comp	oleting Form:	

Instructions:

Does the patient present with problems in any of the following domains.....? If so please rate the severity of the symptoms by circling a number beside that situation that best describes how severe the problem is for the patient. If the patient does not have a problem in a situation circle None and go on to the next situation on the Form.

		None	Mild	Moderate	Severe	Extreme
1	Aggressive Outburst	1	2	3	4	5
2	Agitation	1	2	3	4	5
	Anger	1	2	3	4	5
	Appetite High	1	2	3	4	5
e	Appetite Low	1	2	3	4	5
	Avoiding Familiar Situations	1	2	3	4	5
	Carelessness	1	2	3	4	5
	Crying Spells	1	2	3	4	5
	Decreased Concentration	1	2	3	4	5
)	Decreased Interests	1	2	3	4	5
L	Distractibility	1	2	3	- 4	5
2	Eating Less	1	2	3	4	5
	Eating More	1	2	3	4	5
	Energy High	1	2	3	4	5
	Energy Low	1	2	3	4	5
_	Excessive Involvement in Pleasurable activity	1	2	3	4	5
	Fatigue	1	2	3	4	5
	Feeling Detached	1	2	3	4	5
	Feeling Numb	1	2	3	4	5
	Feeling Worthless	1	2	3	4	5
	Feeling Hopeless	1	2	3	4	5
	Flashbacks	1	2	3	4	5
	Focus Decreased (Distractibility)	1	2	3	4	5
	Focus Increased (Hyper focus)	1	2	3	4	5
	Hallucinations	1	2	3	4	5
_	Impulsivity	1	2	3	4	5
	Insecurity	1	2	3	4	5
	Irritability	1	2	3	4	5
	Isolation	1	2	3	4	
	Memory	1	2	3	4	5
and the last	Mood High	1	2	3	4	
	Mood Low	1	2	3	4	5
	Nightmares	1	2	3	4	5
	Odd Beliefs	1	2	3	4	5
	Peer Interactions	1	2	3	4	5
-	Poor Socialization Skills	1	2	3	CONTRACTOR OF THE PARTY OF THE	
	Recurrent thoughts of Death	1	2		4	5
	Repetitive thoughts	1		3	4	5
	Restlessness	1	2	3	4	5
	Self Esteem Increased		2	3	4	5
		1	2	3	4	5
	Self Esteem Low	1	2	3	4	5
	Sleep Decreased	1	2	3	4	5
	Sleep Increased	1	2	3	4	5
	Talkative (Faster than usual)	1	2	3	4	5
	Talkative (More than usual)	1	2	3	4	5
	Vomiting to lose weight	1	2	3	4	. 5
	Weight Decrease	1	2	3	4	5
	Weight Increase	1	2	3	4	5
	Worries (Excessively)	1	2	3	4	5
0	Worries (Unrealistic)	1	2	3	4	5