# Elizabeth Cordes, D.O.

1616 E 19th Street, Suite 305 Edmond, OK 73013

## *Adult Personal History Inventory and Assessment*

In order to assist your psychiatrist in understanding you and the issues you are experiencing, please complete the following questions completely and honestly. All information will be handled in a manner, which protects confidentiality. We appreciate your cooperation and will assist you if you have any difficulty answering questions.

### General Information

Name: _____ Today's Date: _____

What is the presenting issue(s) that brought you in today? _____

_____

_____

How long has this issue(s) been bothering you? _____

What are your goals for treatment? _____

_____

Do you have any strong feelings about how this should be accomplished? _____

_____

### Medical History

Age _____ Date of Birth _____ Weight _____ Height _____

Primary Care Physician's name _____ Physician's phone _____

Date of Last Physical Examinations _____

Current Medical Conditions/ Concerns: _____

_____

_____

How would you describe your current state of health? _____

**Hospitalizations** (Please include the illness/ operation and the year):

_____ _____

_____ _____

_____ _____

**Past Medical & Family History**—Please check if you (self) or any blood relatives have ever had any of the following:

| | Self | Relation | | Self | Relation |
|---|---|---|---|---|---|
| 1. Recent Weight loss or gain | | **N/A** | 17. Bowel Problems | | |
| 2. Migraine Headaches | | | 18. Liver Disease/ Hepatitis | | |
| 3. Seizure Disorder/ Convulsions | | | 19. Kidney or Bladder | | |
| 4. Eye Disease (other than glasses) | | | 20. Neurological Condition | | |
| 5. Hearing Disorder | | | 21. Arthritis | | |
| 6. Dizziness or Fainting | | | 22. Osteoporosis | | |
| 7. Food Allergy | | | 23. Bleeding Disorder | | |
| 8. Angina/ Chest Pain | | | 24. Restless Leg Syndrome | | |
| 9. Heart Attack | | | 25. Anemia | | |
| 10. High Blood Pressure | | | 26. Diabetes | | |
| 11. High Cholesterol | | | 27. Thyroid | | |
| 12. Stroke | | | 28. Insomnia | | |
| 13. Heart Valve Disorder | | | 29. Sleep Apnea | | |
| 14. Lung Disease | | | 30. Chronic Pain | | **N/A** |
| 15. Stomach Ulcer/ Gastritis | | | 31. Cancer: type | | |
| 16. Irritable Bowel Syndrome | | | | | |

**DRUG ALLERGIES:** _____

**Current Medications**: (Both prescription and OTC) Please include medications taken as needed.

| Name | Dose | How often? | Reason for? | How long? | RX'd by? | Side Effects? |
|---|---|---|---|---|---|---|
| | | | | | | |
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**Vitamins, Supplements, and Herbals** (examples: calcium, Fish Oil pills, ginseng)

| Name | Dose | How often? | Reason for? | How long? | Benefit? | Side Effects? |
|---|---|---|---|---|---|---|
| | | | | | | |
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*For Women Only:*

Date of Last Menstrual Cycle _____ Regular cycles? ( )Yes ( )No Current Birth Control _____
PMS/PMDD? ( )Yes ( )No #Pregnancies _____ #Births_____ # Abortions_____ #Miscarriages_____
OB/GYN?_____ Date of Last Pap/Pelvic Exam?_____

**Substance Use**

Do you now or have you ever consumed/used:

| | | |
|---|---|---|
| Cigarettes/tobacco products? | ( )Yes ( )No | Pkg/Day? _____ #Years? _____ |
| Alcohol? | ( )Yes ( )No | Drinks/Wk _____ |
| Coffee/ Tea/ Sodas? | ( )Yes ( )No | Cups/Day _____ |
| Street Drugs? | ( )Yes ( )No | |

**Developmental: Family/Social**

Was there anything unusual about your birth and infancy? ( )No ( )Yes_____
How old were your parents when you were born? Mother _____ Father _____
During your childhood (age birth to 18) did you have any serious illness or injuries? ( )No ( )Yes_____
With whom did you live as a child? (Please list & include the ages during which you lived with them; eg. Biological parents, mother, grandmother, foster parents, etc.)

_____
Was your childhood happy? ( )Yes ( )No _____
_____
Where did you grow up? _____
How would you describe your relationship with your father during your childhood? _____
_____
How is your relationship with your father now? _____
_____
How would you describe your relationship with your mother during your childhood? _____
_____
How is your relationship with your mother now? _____
_____
At what age did you leave your childhood home? _____ Reason? _____

Please list your brother(s) and/or sister(s) with their ages:

_____ _____ _____

_____ _____ _____

How did you get along with your brother(s) and sister(s) as a child? _____

_____

How do you get along with your brother(s) and sister(s) now? _____

_____

As an adult, have you ever been in trouble with the law (other than minor traffic violations)? ( )No ( )Yes _____

_____

During your childhood, were you ever in trouble with the law? ( )No ( )Yes _____

_____

Is there a history of mental illness, alcohol/drug dependence or suicide in your family? ( )Yes ( )No

If yes, who: _____

Did you have close friends during your childhood? ( )Yes ( )No

Do you have close friends now? ( )Yes ( )No

What role do family and/or friends play in your life? _____

_____

Who do you consider your support system? _____

Have you ever been a victim of abuse: ( )Yes ( )No

If Yes, was it: ( ) Physical ( ) Sexual ( ) Verbally/Emotional

At what age(s) and by whom did you experience the abuse? _____

Did you seek/receive treatment? _____

## EDUCATION

Did you do well in school while you were growing up? ( )Yes ( )No

Any problems or concerns? _____

How far did you go in school? _____

Why did you stop? _____

Do you have plans for further education/training? ( ) No ( ) Yes _____

## CULTURAL/ MORAL BELIEFS

Do you consider yourself to be part of any cultural or ethnic group? ( )No ( )Yes _____

Is there anything about your cultural beliefs of which you would like me to be aware? ( )No ( )Yes _____

_____

What is your religious/spiritual background? _____

_____

Do you consider yourself to be a religious person? _____

Do you consider yourself to be a spiritual person? _____

How do your religions and/or spiritual beliefs affect your life? _____

_____

How are your religious/spiritual beliefs incorporated into your life? _____

_____

What gives your life meaning? _____

_____

## MARITAL

Current marital status? ( ) Single ( ) Married ( ) Divorced ( ) Separated ( ) Widowed ( ) Committed Relationship

Have you been married or lived as married more than one time? ( )No ( ) Yes: total number of times _____

How long has your present or most recent marriage/relationship lasted? _____

If married/living as married, do you and your partner differ in attitudes on any of the following:

( ) Sexual matters ( ) Leisure activities ( ) Religion ( ) Raising children ( ) Finances

( ) Infidelity ( ) Women's role in the family ( ) Man's role in the family ( ) Drug/Alcohol Use

Have any of your marriages/relationships involved domestic violence/abuse? ( ) No ( ) Yes

If yes, please explain: _____

_____

Is there anything else about your marriage(s), relationship(s) or divorce(s) you would like me to know? _____
_____
_____

Do you have children? ( ) Yes ( ) No Are they a product of your current relationship? ( ) Yes ( ) No
What are their names, ages, and gender: _____ _____
_____ _____
_____ _____

Do your children live with you? ( ) No ( ) Yes, Full time ( ) Yes, Part time
Do you have to take care of anyone else? ( ) No ( ) Yes _____

**RECREATION/LEISURE**

What do you do for fun? _____
What are your hobbies/interests? _____
How often do you exercise? ( ) Never ( ) Rarely ( ) 2-3x month ( ) 1x week ( ) 3-5x week ( ) Daily
What type of exercise do you do/ enjoy? _____
What physical activity do you participate in? _____
What do you do to relax? _____
_____
How do you currently relieve stress? _____
Do you belong to any clubs, groups, or organizations? ( )No ( )Yes _____
Do you feel you currently have sufficient "time for yourself"? ( )Yes ( )No

**OCCUPATIONAL**

What is your employment status? ( ) Full-time Employed ( ) Part-time Employed ( ) Self-Employed ( ) Unemployed ( ) Retired ( ) Disabled ( ) Stay-at-home Mom
If you are currently employed, where do you work?_____
What is your position/ nature of your work? _____
How long have you worked there? _____
How many hours per week do you usually work? _____
Are you satisfied with your current employment situation? ( )Yes ( )No
If no, what would you rather do? _____
How many times during your adult lifetime have you changed jobs? _____
Do you consider yourself Disabled? ( )Yes ( )No
If so, in what way? _____
Do you receive disability benefits? ( )Yes ( )No
If so, from whom? _____

**MILITARY**

Have you ever served in the military? ( ) Yes ( ) No (If no, please skip the remaining questions)
Please describe your military experience: _____
_____
Branch of service: _____ Age at enlistment/draft: _____
MOS: _____
Tour of duty dates: _____
Combat duty: ( ) Yes ( ) No When: _____ Where: _____
_____
Type of discharge: _____
Is there anything else that you would like me to know about your military experience? ( ) No ( ) Yes _____
_____