CARY BEHAVIORAL HEALTH PC

160 N.E. MAYNARD ROAD, SUITE # 200, CARY, NC 27513.
PHONE 919-466-7540 FAX 919-466-7543

SELF-ASSESSMENT
Please Print

Name		**Date:**
Street		**Suite/Apt. #**
City, State		**Zip Code**
Phone (home)	**Phone (cell/work)**	
Age	**Date of Birth (month/day/year)**	
Emergency Contact		**Relationship**
Street		**Suite/Apt. #**
City, State		**Zip Code**
Phone (home)	**Phone (cell/work)**	

Gender		**Marital Status**	
Female	□	Never Married □	Living Cooperatively □
Male	□	Married □	Divorced □
Occupation		If married, how many times?	If divorced, how many times?
		Separated □	Widow/Widower □

Education (please specify highest year completed and degree)		
High School	College University	Graduate School

Please state the principal reason you are requesting a consultation or treatment.

Please describe your illness from the time of your first symptom to the present. Proved as many dates, names, addresses of psychiatrists, psychologists, and/or social workers who have treated you as you can. Also, please provide the kinds of treatment you have received, including names of medications and your response to them.

Drinking (Alcohol Use)

How many drinks do you consume in the average day?
At what time of day do you have your first drink?
What is the most you have had to drink in a 24hr period during the last year?
Check if you have ever felt you were or someone told you that you were drinking too much. □
If "yes", what were the circumstances?

Drugs of Abuse

Check if you have taken any of the following drugs.

None □
Marijuana □
Amphetamines/speed □
Heroine/opiates □
PCP □
LSD/hallucinogens □
Cocaine/crack □
Barbiturates/sedatives/downers
If you checked one or more of the drugs, under what circumstances did you take it (them).

When did you most heavily use drugs?
When was the last time you took such drugs?

Medical Problems

Age when first occurred	List all past & present medical problems as well as any surgery or accident.

Personal History

Check any items that apply to you

Mothers pregnancy with you was abnormal □
Mothers delivery of you was abnormal

Check if during childhood you…

- Were afraid to go to school □
- Had difficulty with readying, writing, or math □
- Were truant □
- Failed or repeated a grade □
- Had frequent falls □
- Were awkward at games □
- Wet bed after age 5 □
- Had tics □
- Had trouble with eyes □
- Were (are) left handed □
- Mispronounced words, had a lisp, stutter/stammer □
- Had nightmares, disturbed sleep, fear of the dark □
- Ran away from home □
- Were cruel to animals □
- Often lied to families or others □
- Set fires □
- Moved often □
- Were exposed to incest □
- Were promiscuous □

Family History/Major Illness

(Include mental illness)

Mother : _____

Father: _____

Siblings: _____

_____

_____

Children: _____

_____

_____

Grandparents, Aunts/Uncles: _____

_____

_____

Mothers pregnancy with you was abnormal ☐
Mothers delivery of you was abnormal

Check if during childhood you…

- Were afraid to go to school ☐
- Had difficulty with readying, writing, or math ☐
- Were truant ☐
- Failed or repeated a grade ☐
- Had frequent falls ☐
- Were awkward at games ☐
- Wet bed after age 5 ☐
- Had tics ☐
- Had trouble with eyes ☐
- Were (are) left handed ☐
- Mispronounced words, had a lisp, stutter/stammer ☐
- Had nightmares, disturbed sleep, fear of the dark ☐
- Ran away from home ☐
- Were cruel to animals ☐
- Often lied to families or others ☐
- Set fires ☐
- Moved often ☐
- Were exposed to incest ☐
- Were promiscuous ☐

Mother : _____

Father: _____

Siblings: _____

_____

_____

Children: _____

_____

_____

Grandparents, Aunts/Uncles: _____

_____

_____

Medical History

Weight and Height

What is your current weight in pounds? lbs.
Check if your weight has increased/decreased by more than 10 lbs. during the last 5 years. ☐
If checked, explain the circumstances

What is your height?

Sleep

(Check any items that apply to you)

- Have difficulty falling asleep ☐
- Have difficulty waking up & falling back to sleep ☐
- Are tired on waking ☐
- Have bad dreams, sleep walk, or other sleep disturbances ☐
- Have sleep apnea or snoring ☐

Smoking

Check if you smoke ☐
If checked, how much & for how long?

Caffeine

Suicide

Check if you have ever thought about suicide ☐
If yes, when was the last time?

Check if you have ever attempted suicide ☐
If yes, when and how?

Check if you have thoughts about suicide now ☐

Injury to others

Check if you have ever thought about hurting someone else ☐
If yes, when was the last time?

Check if you have ever hurt someone else ☐
If yes, when and how?

Check if you are thinking about hurting someone else now ☐

Recent Stressful Life Events

Check any of the following events that have occurred during the last 2 years.

Married ☐

Engaged ☐

Check if you drink coffee, tea, or colas □
If checked, how much?

Allergies

List all allergies. Be sure to include medication allergies.

Females- Menstrual History

Check if your mood, depression, irritability, or irrationality changes with your periods. □
If checked, how?

Separated □
Divorced □
Serious argument □
Breakup of important relationship □
Child left home □
Death of spouse, other □
Bad health (behavior) of family member □
Difficulties with family member □
Personal injury, illness □
Sexual difficulties □
Difficulties, changes at school, work □
Retired, lost job □
Changed residence □
Legal difficulties, multiple traffic tickets □
Owe money □