ELEMENTAL CLINIC

NEW PATIENT MENTAL HEALTH HISTORY

Dr. Martins Adeoye & Associates

1323 Butterfield Rd, Suite 116
Downers Grove, IL 60515
Office Phone: (331)-330-9955
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15010 S. Ravinia Ave, Suite 15
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612 S Western Ave, Unit 1
Chicago, IL, 60612
OfficePhone: (331)-330-9955
Fax: (331)-330-9930

Personal Information

First Name _____ Last Name _____ Gender _____ DOB _____

Address _____ City _____ State _____ ZIP Code _____

OK to leave a message? ☐Yes ☐ No

Social Security # _____ Phone _____

Email _____ Referral Source _____

Emergency Contact Information

First Name _____ Last Name _____

Phone # _____ Relationship _____

Mental Health Providers

Current Psychiatrist: _____ Phone# _____

Current Therapist/Counselor: _____ Phone # _____

Have you ever been hospitalized for psychiatric reasons? ☐ Yes ☐ No How many times? _____

If Yes: What Year(s)? _____What was the reason? _____

Have you ever been in a Partial Hospitalization Program (PHP) or Intensive Outpatient Program (IOP)? ☐ Yes ☐ No

Where and When? _____

Current Symptoms:

☐	Depressed Mood	☐	Increased libido	☐	Bulimia
☐	Anxiety	☐	Impulsivity	☐	Binge Eating
☐	Unable to Enjoy Activities	☐	Decrease need for sleep	☐	Anorexia
☐	Sleep pattern disturbance	☐	Excessive energy	☐	Alcohol Use
☐	Loss of Interest	☐	Increased irritability	☐	Marijuana Use
☐	Concentration/Forgetfulness	☐	Crying spells	☐	Opiates Use
☐	Change in Appetite	☐	Excessive worry	☐	Cocaine Use
☐	Excessive Guilt	☐	Panic attacks	☐	Sedatives Use
☐	Fatigue	☐	Avoidance	☐	Stimulants Use
☐	Decreased libido	☐	Hallucinations	☐	Hallucinogens Use
☐	Racing thoughts	☐	Paranoia	☐	Methamphetamines
☐	Increased Risky Behavior	☐	Self-injury	☐	Other: _____

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Suicide/Self Harm Risk Assessment:

Have you ever had thoughts that you did not want to live? ☐ Yes ☐ No
If yes, answer the following. *If No, please skip to the Violence Risk Assessment.*
Do you **currently** feel that you do not want to live? ☐ Yes ☐ No
How often do you have these thoughts? _____
When was the last time you had thoughts of dying? _____
Have you ever thought about how you would kill yourself? If so, list how _____
Have you ever attempted to kill or harm yourself before (includes attempted suicide and/or self harm)? ☐ Yes ☐ No
When and how? _____
On a scale 1 – 10, 10 being the strongest, how strong is your desire to kill/harm yourself currently? _____
Do you have a access to a gun or other lethal weapon? ☐ Yes ☐ No

Violence Risk Assessment:

Have you ever had thoughts that you want to hurt or kill other people? ☐ Yes ☐ No
If yes, how often do you have these thoughts? _____

Abuse History

Do you have a history of being abused: **Verbally** ☐ Yes ☐ No **Physically** ☐ Yes ☐ No **Sexually** ☐ Yes ☐ No
Do you still have interaction with the perpetrator: ☐ Yes ☐ No Were the authorities ever involved? ☐ Yes ☐ No

Prescription Medications (LIST ALL RX MEDICATIONS - PSYCHIATRIC AND MEDICAL)

Medications	Date	Dosage/Frequency	Response/Side effects

Over the Counter Medications/Supplements

Medications	Date	Dosage/Frequency	Response/Side effects

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Family Psychiatric History

Is there a family history of any of the following mental health/substance abuse issues?

☐	Bipolar Disorder	☐ Yes ☐ No	☐	Schizophrenia	☐ Yes ☐ No		
☐	Depression	☐ Yes ☐ No	☐	PTSD	☐ Yes ☐ No		
☐	Anxiety	☐ Yes ☐ No	☐	Alcohol Abuse	☐ Yes ☐ No		
☐	Anger	☐ Yes ☐ No	☐	Other Substance Use	☐ Yes ☐ No		
☐	Suicide	☐ Yes ☐ No	☐	Violence	☐ Yes ☐ No		

If yes: Who, and for which mental illness: _____

Substance Use Assessment

Have you ever been treated for Alcohol and/or Drug use? ☐ Yes ☐ No

If yes: Which substances were you treated for? _____

How much do you usually consume when you drink alcohol? _____

Do you think you have a problem with alcohol or drug use? ☐ Yes ☐ No

Do any friends or family think you have a problem with alcohol or drug use? ☐ Yes ☐ No

Have you ever used any illegal drugs or abused prescription medication? ☐ Yes ☐ No

If yes: Please list Which/Date of last use/Frequency of use: _____

Check if you have ever tried the following:		If Yes, For how long, and when did you last use?
☐	Alcohol	☐ Yes ☐ No _____
☐	Cocaine	☐ Yes ☐ No _____
☐	Stimulants pills	☐ Yes ☐ No _____
☐	Heroin	☐ Yes ☐ No _____
☐	LSD or Hallucinogens	☐ Yes ☐ No _____
☐	Marijuana	☐ Yes ☐ No _____
☐	Pain killers	☐ Yes ☐ No _____
☐	Methadone	☐ Yes ☐ No _____
☐	Tranquilizer/sleeping pills/benzo	☐ Yes ☐ No _____
☐	Ecstasy	☐ Yes ☐ No _____
☐	Methamphetamine	☐ Yes ☐ No _____
☐	Other:_____	_____

Tobacco Use Assessment

Do you currently smoke cigarettes? ☐ Yes ☐ No If yes, how many packs per day do you smoke?

_____

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How many years? _____ Have you smoked in the past? ☐ Yes ☐ No How many years did you smoke?_____

Do you use smokeless tobacco? ☐ Yes ☐ No Do you vape nicotine? ☐ Yes ☐ No

Medical History

Primary Care Physician: _____ Phone # _____

MEDICATION ALLERGIES: _____

Current Weight: _____ Height: _____

Medical problems: _____

Non-psychiatric hospitalizations, surgeries: _____

Date of last physical exam: _____

For women only: Date of last menstrual period: _____ Are you currently pregnant? ☐ Yes ☐ No

Personal and Family History

	YOU	Family	Which Family Member
Allergies	☐	☐	_____
Anemia	☐	☐	_____
Asthma/Respiratory Problems	☐	☐	_____
Cancer	☐	☐	_____
Diabetes	☐	☐	_____
Chronic fatigue	☐	☐	_____
Chronic pain	☐	☐	_____
Epilepsy or seizures	☐	☐	_____
Head Trauma	☐	☐	_____
High Cholesterol	☐	☐	_____
High Blood Pressure	☐	☐	_____
HIV/AIDS	☐	☐	_____
Heart Disease	☐	☐	_____
Fibromyalgia	☐	☐	_____
Kidney Disease	☐	☐	_____
Liver Disease	☐	☐	_____
Stomach or Intestinal problems	☐	☐	_____
Stroke	☐	☐	_____
Thyroid Disease	☐	☐	_____

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Educational History

What is your highest educational level or degree attained? _____

Occupational History

Please check your status: ☐ Full-time ☐ Part--time ☐ Student ☐ Disabled ☐ Retired ☐ Unemployed

Occupation? _____

Military Status

Are you a military veteran? ☐ YES ☐ NO Are you active duty? ☐ YES ☐ NO

Relationship History and Current Family

Please check your status: ☐ Married ☐ Partnered ☐ Divorced ☐ Single ☐ Widowed

Do you have any children? _____ If yes, list ages and gender:_____

Legal History

Have you ever been arrested? ☐ Yes ☐ No Do you have any pending legal matters? ☐ Yes ☐ No

Are you mandated by the Court to receive mental health treatment? ☐ Yes ☐ No

Goals and Needs

Why are you seeking services at Elemental Center? _____

Please list your therapeutic goals:

1. _____
2. _____
3. _____
4. _____

_____ _____

Patient Signature **Date**

_____ _____

Guardian Signature (if under age 18) **Date**

For office use only:

_____

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SCANNED/UPLOADED BY (STAFF NAME)

_____

Date