



# F.A.S.T

BEHAVIORAL  
HEALTH CLINIC

## Form A- Patient Self Report

Name:		DOB:	Age:	Gender: M F
Ethnicity:		Address:		
Main Support system:			Marital Status:	
Preferred Language:		Occupation:		
Emergency Contact:		Relationship:	Phone No:	
Do you currently see a psychiatric provider?		Name & Phone #:		
Do you currently see a psychotherapist?		Name & Phone#:		<input type="checkbox"/> Need referral
Reason for service:				

**PSYCHIATRIC HISTORY: Have you ever been diagnosed and/or treated for any of the following conditions?**

<input type="checkbox"/> Major Depressive Disorder	<input type="checkbox"/> Bipolar Disorder (manic/depressive)	<input type="checkbox"/> ADHD
<input type="checkbox"/> Anxiety Disorder	<input type="checkbox"/> Schizophrenia	<input type="checkbox"/> OCD
<input type="checkbox"/> Panic Disorder	<input type="checkbox"/> Schizoaffective Disorder	<input type="checkbox"/> PTSD
<input type="checkbox"/> Substance Use Disorder	<input type="checkbox"/> Anorexia/Bulimia	<input type="checkbox"/> Binge Eating
<input type="checkbox"/> Alcohol use disorder (including AA)	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:

**PAST MEDICAL HISTORY: Have you ever had any of the following medical conditions?**

<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Asthma	<input type="checkbox"/> Overweight/ Obesity
<input type="checkbox"/> Cancer	<input type="checkbox"/> Chronic pain	<input type="checkbox"/> Traumatic Brain Injury
<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Stroke
<input type="checkbox"/> STDs (list):	<input type="checkbox"/> Other (list):	

Have you ever been hospitalized in psychiatric facility?  No  Yes, how many times? \_\_\_\_\_

List in chronological order the 2 most recent hospitalizations (if any):

Approximate Date	Length of Stay	Name of Hospital	Reason for Admission

Have you ever been in a psychiatric Partial Hospitalization Program (PHP)?  No  Yes, how many times? \_\_\_\_\_

List in chronological order the 2 most recent PHP (if any):

Approximate Date	Length of Stay	Name of Institution	Reason for Admission

Have you ever attempted to harm/kill yourself?  NO  YES, How many times? \_\_\_\_\_

If YES, please list the two most recent occurrences below:

Approximate date of attempt	Method (How did you attempt?)	Did you go to the ER? Where?	Hospitalized? Where?

Please, list below all **CURRENT PSYCHIATRIC** medications:

Medication	Dosage (mg)	Times per day	For how long?	Side effects

Have you ever been a victim of abuse?  NO  YES

Emotional		Physical		Sexual	
<input type="checkbox"/> Childhood	<input type="checkbox"/> Adult	<input type="checkbox"/> Childhood	<input type="checkbox"/> Adult	<input type="checkbox"/> Childhood	<input type="checkbox"/> Adult

Please list a detailed history of previous/current substance use (drugs, alcohol or other illicit substances)

Name of drug	For how long	Last used