Patient Name:
Date of Birth:
MRN: Office Use Only

Stony Brook Psychiatric Associates, P.C.
Psychiatry Outpatient Services
Patient Information

As part of our assessment, we want to understand who you are as a person. We want to hear about your goals, your strengths and skills and the challenges that you have overcome. We also want to learn about any issues that you want to address as a part of your treatment. We will work closely with you to develop an individualized plan for your care. **Please place a check mark next to any of the items below that you would like us to discuss and address in this treatment planning process.** Also, place a check mark next to any issues that might make it challenging for you to participate in your treatment.

Personal care skills		Family relationships		Sleep difficulties		Housing concerns	
Coping skills		Family stressors		Sexual difficulties		Transportation concerns	
Communication skills		Support networks		Fear of falling		Insurance or other benefits	
Social skills		Physical or dental health		Anger management problems		Cultural issues	
Employment		Smoking cessation		Thoughts of harming yourself		Spiritual or religious issues	
Education		Weight or eating problems		Thoughts of harming others		Legal problems	

Fill in the blanks and circle any answers that apply to you.

Describe any other issues that you would like to have addressed: _____

_____

How do you learn best about new topics? Seeing Hearing Doing No preference

What language do you prefer for written information? _____

What language do you prefer for spoken information? _____

Do you have problems with hearing or eyesight that would affect learning? Yes No

Are you experiencing any pain? Yes No If yes, describe: _____

Do you have a medical advance directive? Yes No

Do you have a psychiatric advance directive? Yes No

Do you have a health care proxy? Yes No

Do you have a preference about your treatment? No preference Self-help Psychotherapy Medication

Would you like information about your diagnosis? Yes No Would you like information about your treatments? Yes No

Would you like your family to have information about your diagnosis or treatment? Yes No

In the box below, please tell us about the skills that you have and what things make you happy or proud about yourself. Also, tell us your goals of what you would like to do in the future.

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What allergies do you have? _____

What is your current weight? _____

What is your current height? _____

Are there any changes in your physical health that we should be aware of? _____

_____

_____

Please complete these questions about your use of tobacco, alcohol and drugs by circling your answer.

Are you a smoker? Yes No
Have you ever been a smoker? Yes No
Do you use any other types of tobacco products, such as cigars, pipes, or chewing tobacco? Yes No
How often did you have a drink containing alcohol in the past year? Never Monthly or less 2-4 times a month 2-3 times a week 4 or more times a week
How many drinks did you have on a typical day when you were drinking in the past year? I do not drink 1 or 2 3 or 4 5 or 6 7 to 9 10 or more
How often did you have six or more drinks on one occasion in the past year? Never Less than monthly Monthly Weekly Daily or almost daily

The following questions concern information about your use of drugs other than alcohol and tobacco during the **past 12 months**. Carefully read each statement and mark your answer as "Yes" or "No" in the appropriate box. When the words "drug abuse" are used, they mean the use of prescribed or over-the-counter medications in non-directed ways and any non-medical use of drugs. Classes of drugs may include: cannabis (i.e. marijuana), tranquilizers (i.e. Valium/Xanax), solvents, barbiturates, cocaine, stimulants (i.e. speed), hallucinogens (i.e. LSD) or narcotics (i.e. heroin). Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right. Remember that the questions refer to the **past 12 months** and do not include alcohol or tobacco.

	Yes	**No**
Have you used drugs other than those required for medical reasons?		
Do you abuse more than one drug at a time?		
Are you always able to stop using drugs when you want to?		
Have you had "blackouts" or "flashbacks" as a result of drug use?		
Do you ever feel bad or guilty about your drug use?		
Does your spouse (or parents) ever complain about your involvement with drugs?		
Have you neglected your family because of your use of drugs?		
Have you engaged in illegal activities in order to obtain drugs?		
Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?		
Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding, etc.)?		

(Questions are from the AUDIT-C version of the Alcohol Use Disorders Identification Test, published in Addiction 88: 791-804, 1993 and the DAST-10 version of the Drug Abuse Screening Test developed by Harvey A Skinner and published in Addictive Behavior 7(4):363-71, 1982.)