

# STUDENT HEALTH & WELLNESS

University of Iowa  
4189 Westlawn  
Iowa City, Iowa 52242

[Patient label goes here]

Patient's Name \_\_\_\_\_

Student ID# \_\_\_\_\_ : Age \_\_\_\_\_

## PSYCHIATRY HEALTH HISTORY FORM

This information will be considered protected health information and will become part of your medical record subject to the conditions stated in the University of Iowa Health Care's Privacy Notice.

Today's Date: \_\_\_\_\_ Preferred Name if different from above: \_\_\_\_\_

Undergraduate  Graduate Major: \_\_\_\_\_ Graduation Date: \_\_\_\_\_ Current GPA: \_\_\_\_\_

**Did anyone refer you today?**  University Counseling Service  Student Health & Wellness  Self  Other \_\_\_\_\_

Briefly describe the problem that prompted you to make the appointment.

### **Past Medical History:**

History of surgeries: \_\_\_\_\_

History of medical problems: \_\_\_\_\_

Current medical conditions: \_\_\_\_\_

Current medications: \_\_\_\_\_

Allergies – Drug \_\_\_\_\_ Food/Environmental \_\_\_\_\_

### **Past Psychiatric History:**

History of counseling/therapy: (Indicate when, where, name of counselor) \_\_\_\_\_

\_\_\_\_\_

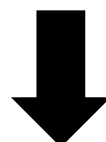
Previous trials of psychiatric medications:

Medications	Dates Taken	Maximum Dose	Side Effects	Was it helpful?

Previous psychiatric hospitalization: (Indicate when and where) \_\_\_\_\_

\_\_\_\_\_

**-- PLEASE FLIP OVER FOR SIDE 2 --**



**Family History**

- Adopted
- Family History Unknown

*Unknown*  
*Depression*  
*Anxiety*  
*Bipolar*  
*Schizophrenia*  
*Substance Abuse*  
*Thyroid*  
*Other*

Relationship	Age	Living?																		Comment
Mother		Yes No																		
Father		Yes No																		
Sibling <input type="checkbox"/> Sister <input type="checkbox"/> Brother		Yes No																		
Sibling <input type="checkbox"/> Sister <input type="checkbox"/> Brother		Yes No																		
Sibling <input type="checkbox"/> Sister <input type="checkbox"/> Brother		Yes No																		
Sibling <input type="checkbox"/> Sister <input type="checkbox"/> Brother		Yes No																		
Maternal Grandmother		Yes No																		
Maternal Grandfather		Yes No																		
Paternal Grandmother		Yes No																		
Paternal Grandfather		Yes No																		
Extended Family		Yes No																		
		Yes No																		
		Yes No																		
		Yes No																		

**Social History:**

Father's Name \_\_\_\_\_ Occupation \_\_\_\_\_

Mother's Name \_\_\_\_\_ Occupation \_\_\_\_\_

Parent's marital status  Married  Divorced (when) \_\_\_\_\_  Separated (when) \_\_\_\_\_

What town(s) did you grow up in? \_\_\_\_\_

Siblings: Brothers (list name, age) \_\_\_\_\_

Sisters (list name, age) \_\_\_\_\_

Describe past/current family difficulties : \_\_\_\_\_

ACT Scores (or SAT scores): Composite \_\_\_\_\_ English \_\_\_\_\_ Math \_\_\_\_\_ Reading \_\_\_\_\_ Science \_\_\_\_\_

Education: High School \_\_\_\_\_ Year Graduated \_\_\_\_\_ GPA/Rank \_\_\_\_\_

Previous college / community college: \_\_\_\_\_

Legal: Have you ever been arrested/convicted of a crime? \_\_\_\_\_

Relationship Status:  Single  Married  Divorced  Partnered \_\_\_\_\_

Living Situation:  On Campus  Off Campus  With Family - How Many roommates? \_\_\_\_\_

How much do you exercise, what form? \_\_\_\_\_

Any tobacco use? Smokeless, (chewing, snuff)  Never  In the past, not now  Current

Cigarettes?  Never  In the past, not now  Current

Any additional information you would like us to know?

Signature

Date

## PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the **last 2 weeks**, how often have you been bothered by any of the following problems?

(Use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING   0   + \_\_\_\_\_ + \_\_\_\_\_ + \_\_\_\_\_  
=Total Score: \_\_\_\_\_

If you checked off **any** problems, how **difficult** have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult  
at all

Somewhat  
difficult

Very  
difficult

Extremely  
difficult

Patient's Name \_\_\_\_\_

Student ID: \_\_\_\_\_ or MRN \_\_\_\_\_

## GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems?

(Use "✓" to indicate your answer)

Over the <u>last 2 weeks</u> , how often have you been bothered by the following problems? (Use "✓" to indicate your answer)	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

**(For office coding: Total Score T\_\_\_\_\_ = \_\_\_\_\_ + \_\_\_\_\_ + \_\_\_\_\_ )**