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

Relationship	Age	Living?	Unknown	Depression	Anxiety	Bipolar	Schizophrenia	Substance Abuse	Thyroid	Other	Comment
Mother		Yes No									
Father		Yes No									
Sibling □Sister □Brother		Yes No									
Sibling □Sister □Brother		Yes No									
Sibling □Sister □Brother		Yes No									
Sibling □Sister □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 label goes here]

Patient's Name_____

Student ID :_____or MRN_____

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 label goes here]

Patient's Name_____

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GAD-7

Over the last 2 weeks, 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____ = ____ + ____ + ____)

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc.