AMEN CLINICS HISTORY UPDATE

PATIENT INFORMATION
Please use **BLUE** or **BLACK** ink and write **LEGIBLY.**
Patient's Name: ____ Date of Birth: _________________________

Home Address: ____

Home Phone: (________)__________________Cell Phone: (________)_________________

RESPONSIBLE PARTY ☐ no changes

Responsible Party: ____ SS#______ - _____ - _____ Date of Birth: ____________Age: _______

Home Address: ____

Home Phone: (_________)______________________________ Cell Phone: (_____)__________________________

Please complete the following to give us an update. You only need to include information that has changed since your last visit with the clinic. Today's date: ______________

What are your goals in reestablishing care with the Amen Clinic?

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PROGRESS REPORT ON TARGET SYMPTOMS (Check all that apply)

	Improved	No Change	Worse
Anxiety	[ ]	[ ]	[ ]
Panic Attacks	[ ]	[ ]	[ ]
Phobias	[ ]	[ ]	[ ]
Obsessions or Compulsions	[ ]	[ ]	[ ]
Anorexia Nervosa	[ ]	[ ]	[ ]
Bulimia (binging and purging)	[ ]	[ ]	[ ]
Depression	[ ]	[ ]	[ ]
Seasonal Mood Changes (SAD)	[ ]	[ ]	[ ]
Grief	[ ]	[ ]	[ ]
Elevated Mood	[ ]	[ ]	[ ]
Bipolar Illness	[ ]	[ ]	[ ]
Mania	[ ]	[ ]	[ ]
Anger or Rage Problems	[ ]	[ ]	[ ]
Irritability	[ ]	[ ]	[ ]
Defiant Behavior	[ ]	[ ]	[ ]
Fire Setting	[ ]	[ ]	[ ]
Bedwetting	[ ]	[ ]	[ ]
Cruelty to Animals	[ ]	[ ]	[ ]
Legal Troubles	[ ]	[ ]	[ ]

	Improved	No Change	Worse
Self-Mutilation	[ ]	[ ]	[ ]
Suicide Attempts	[ ]	[ ]	[ ]
Psychiatric Hospitalization	[ ]	[ ]	[ ]
Social Isolation	[ ]	[ ]	[ ]
Hallucinations	[ ]	[ ]	[ ]
Schizophrenia	[ ]	[ ]	[ ]
Psychosis	[ ]	[ ]	[ ]
Paranoia	[ ]	[ ]	[ ]
Delusions	[ ]	[ ]	[ ]
Dissociative States	[ ]	[ ]	[ ]
ADHD (Attention Deficit Disorder)	[ ]	[ ]	[ ]
Concentration Difficulties	[ ]	[ ]	[ ]
Attention Difficulties	[ ]	[ ]	[ ]
Hyperactivity	[ ]	[ ]	[ ]
Intolerance of Boredom	[ ]	[ ]	[ ]
Learning/School Difficulties	[ ]	[ ]	[ ]
Laxative/Diuretic Abuse	[ ]	[ ]	[ ]
Alcohol Abuse	[ ]	[ ]	[ ]
Drug/substance abuse	[ ]	[ ]	[ ]
Tourette's Syndrome	[ ]	[ ]	[ ]
Amnesia	[ ]	[ ]	[ ]
Dementia	[ ]	[ ]	[ ]
Mental Retardation	[ ]	[ ]	[ ]
Autism	[ ]	[ ]	[ ]
Asperger's Disorder	[ ]	[ ]	[ ]
Pervasive Developmental Disorder	[ ]	[ ]	[ ]
Sensitivity to light	[ ]	[ ]	[ ]
Sensitivity to odor	[ ]	[ ]	[ ]
Sensitivity to sound	[ ]	[ ]	[ ]
Sensitivity to touch	[ ]	[ ]	[ ]
Other: ___________________	[ ]	[ ]	[ ]
Other: ___________________	[ ]	[ ]	[ ]
Other: ___________________	[ ]	[ ]	[ ]
Other: ___________________	[ ]	[ ]	[ ]
Other: ___________________	[ ]	[ ]	[ ]
Other: ___________________	[ ]	[ ]	[ ]
Other: ___________________	[ ]	[ ]	[ ]

PAST AND PRESENT PSYCHIATRIC MEDICATIONS AND SUPPLEMENTS

Please indicate all medications and supplements you have taken since your last visit with the Amen Clinics.

Date Taken	**Medication/Supplement** *Individual or Combinations* *Dosage(s) and time(s) taken per day*	**Effectiveness**	**Side-Effects/Problems**
From:_______ To:_________ ☐ Current			
From:_______ To:_________ ☐ Current			
From:_______ To:_________ ☐ Current			
From:_______ To:_________ ☐ Current			
From:_______ To:_________ ☐ Current			
From:_______ To:_________ ☐ Current			
From:_______ To:_________ ☐ Current			
From:_______ To:_________ ☐ Current			
From:_______ To:_________ ☐ Current			
From:_______ To:_________ ☐ Current			
From:_______ To:_________ ☐ Current			
From:_______ To:_________ ☐ Current			
From:_______ To:________ ☐ Current			

Do your current medications and supplements seem to help you as much as you expected they would? ☐ Yes ☐ No

Have you had problems remembering or being able to take your medications and supplements? ☐ Yes ☐ No

Have others commented that they noticed a difference in you due to the medications and supplements? ☐ Yes ☐ No

ATTEMPTS TO CORRECT PROBLEMS

Other than medications and supplements, which recommendations from your evaluation with Amen Clinics have you tried? Were they helpful? ______________________________

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RECENT MEDICAL HISTORY

List new medical problems: ______________________________

____

____

____

Current (non-psychotropic) medications (including over the counter):______________________________

____

____

Current Height _______ Current Weight _______ Current Waist Size_________

Head Trauma/Concussions: ______________________________

____

____

Are there any other doctors you see regularly? Why? ______________________________

____

RECENT OR CURRENT STRESSORS

____

____

____

Current Diet: ☐ Healthy ☐ Unhealthy ☐ In between

Food allergies and/or dietary restrictions:______________________________

____

Caffeine consumption per day (i.e. coffee, soda, tea, chocolate):______________________________

How many days a week do you eat fruits?___________ vegetables?________ breakfast?__________________

Current bowel function:______________________________

Current Exercise: Describe your current exercise regimen:______________________________

____

Sleep Behavior: Problems ☐ falling asleep ☐ staying asleep ☐ waking up

Avg. hours of sleep/night:_____ Other sleep related problems:______________________________

____

Social Changes: Please list any changes to employment, education level, family structure, and other significant events: ______________________________

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Alcohol and Drug History: Any changes in your alcohol or drug consumption?______________________________

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