



Mulchand Chugh, M.D.  
Child, Adolescent and Adult Psychiatrist

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Care Providers**

Prescribing Psychiatrist: \_\_\_\_\_ Phone: \_\_\_\_\_

Current Psychotherapist: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

**Patient Information**

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender (Circle): FEMALE MALE

Status (Circle):

MARRIED/PARTNERED SINGLE/NEVER MARRIED DIVORCED/SEPARATED

Education (Circle):

GRADUATED HIGH SCHOOL SOME COLLEGE COMPLETED COLLEGE GRADUATE

EDUCATION OTHER: \_\_\_\_\_

Work History (Circle):

DISABLED [SINCE: \_\_\_\_\_ DUE TO: \_\_\_\_\_]

UNEMPLOYED [SINCE: \_\_\_\_\_ DUE TO: \_\_\_\_\_]

EMPLOYED [CURRENT JOB: \_\_\_\_\_]

**Early Environment**

On a scale of 0 to 5 (0=not at all 5=extremely), how stressful was your early life (Age 0- 5)?

\_\_\_\_\_

On a scale of 0 to 5 (0=not at all 5=extremely), how stressful was your childhood (Age 6-

12)? \_\_\_\_\_



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On a scale of 0 to 5 (0=not at all 5=extremely), how stressful were your teen years (Age 13-19)? \_\_\_\_\_

Did you experience abuse or neglect during your childhood and/or teen years? \_\_\_\_\_

**Previous history with Depression**

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Describe your life before Depression. Include hobbies and leisure time activities:

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How old were you when you first experienced symptoms of Depression? \_\_\_\_\_

What were some of these symptoms? \_\_\_\_\_

When did you first receive treatment? \_\_\_\_\_

What treatment, if any, did you receive? \_\_\_\_\_

How would you describe your symptoms?      CHRONIC      EPISODES

**Psychiatric History**

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Please provide as much detail as you can, including dates:

Outpatient psychotherapy:

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Outpatient psychiatric medication management:

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Hospital Admission for psychiatric care: \_\_\_\_\_

Hospital Admission for drugs/alcohol detox: \_\_\_\_\_

Drug/alcohol rehab programs: \_\_\_\_\_

Have you ever made a suicide attempt or harmed yourself physically?

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What medications have you taken in the past for your depression? Please list all.

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Which treatment has worked best for relieving your symptoms?

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Describe any negative reaction to a medication taken for depression.

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Current Psychiatric Medications and Doses:

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**Medical History**

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Have you ever had surgery? List Dates and Reason:

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Do you exercise? \_\_\_\_\_

Current Medical Conditions \_\_\_\_\_

History of past seizure/epilepsy \_\_\_\_\_

Do you have any metal surgically implanted or embedded in your body?

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Last time you had a physical check up from your primary care doctor

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**Current Symptoms: Check all that apply**

\_\_\_\_\_ Sleep disturbance: insomnia, Awakening throughout the night, awaken too early

\_\_\_\_\_ No interest in hobbies, leisure activities, recreational activities

\_\_\_\_\_ Appetite disturbance

\_\_\_\_\_ Trouble concentrating or making decisions

\_\_\_\_\_ Feelings of apathy or lack of motivation

\_\_\_\_\_ Low energy, easy fatigue

\_\_\_\_\_ Feeling anxious, tense, nervous or fearful

\_\_\_\_\_ Physical symptoms: pain in body, upset stomach, headaches

\_\_\_\_\_ Sad mood, often tearful

\_\_\_\_\_ Irritable mood or frequent mood swings

\_\_\_\_\_ Negative self-esteem, feeling worthless



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- \_\_\_\_\_ Internal agitation, feeling fidgety
- \_\_\_\_\_ Guilt, feeling like a burden to others
- \_\_\_\_\_ Slow thinking, slow movement or slow talking
- \_\_\_\_\_ Intrusive negative thoughts or unpleasant memories
- \_\_\_\_\_ Trouble socializing with others, need to isolate self
- \_\_\_\_\_ Easily overwhelmed, unable to deal with minor stressors
- \_\_\_\_\_ Staying in bed, sleeping to “escape”
- \_\_\_\_\_ Paranoia or feelings that someone might harm you or monitor you
- \_\_\_\_\_ Hearing a voice or sounds that others don’t hear
- \_\_\_\_\_ Thinking about or planning suicide
- \_\_\_\_\_ Craving or eating junk food, poor nutritional habits

Other:

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Patient’s Signature