OLIVE BRANCH PSYCHOTHERAPY

Dr. Stephen R. Parrish DMFT, LCPC
1601 2nd Ave. North - Suite 514 (Columbus Center) Great Falls, Montana 59401; 406-217-2338

BIOPSYCHOSOCIAL HISTORY

_____ _____ _____/_____/_____
Clients Name Date of Birth Social Security No.

Presenting Problems

Presenting Problems	Duration	Additional Information

CURRENT SYMPTOMS CHECKLIST (Rate Intensity of symptoms currently present)

None = This symptom not present at this time * **Mild** = Impacts quality of life, but no significant impairment of day-to-day functioning
Moderate = Significant impact on quality of life and/or day-to-day functioning * **Severe** = Profound Impact on quality of life and Day-to-day functioning

	None Mild Moderate Severe		None Mild Moderate Severe		None Mild Moderate Severe
depressed mood	I___I___I____I____I	binging/purging	I___I___I____I____I	guilt	I___I___I____I____I
appetite disturbance	I___I___I____I____I	laxative/diuretic abuse	I___I___I____I____I	elevated mood	I___I___I____I____I
sleep disturbance	I___I___I____I____I	anorexia	I___I___I____I____I	hyperactivity	I___I___I____I____I
elimination disturbance	I___I___I____I____I	paranoid ideas	I___I___I____I____I	losing track of time or place	I___I___I____I____I
fatigue/low energy	I___I___I____I____I	overly detailed thoughts	I___I___I____I____I	somatic complaints	I___I___I____I____I
slow movements	I___I___I____I____I	Flight of thoughts	I___I___I____I____I	self-mutilation	I___I___I____I____I
poor concentration	I___I___I____I____I	delusions	I___I___I____I____I	significant weight gain/loss	I___I___I____I____I
poor grooming	I___I___I____I____I	hallucinations	I___I___I____I____I	a medical condition	I___I___I____I____I
mood swings	I___I___I____I____I	aggressive behavior	I___I___I____I____I	emotional trauma victim	I___I___I____I____I
agitation	I___I___I____I____I	conduct problems	I___I___I____I____I	physical trauma victim	I___I___I____I____I
emotionality	I___I___I____I____I	oppositional behavior	I___I___I____I____I	sexual trauma victim	I___I___I____I____I
irritability	I___I___I____I____I	sexual dysfunction	I___I___I____I____I	emotional trauma perpetrator	I___I___I____I____I
generalized anxiety	I___I___I____I____I	grief	I___I___I____I____I	physical trauma perpetrator	I___I___I____I____I
panic attacks	I___I___I____I____I	hopelessness	I___I___I____I____I	sexual trauma perpetrator	I___I___I____I____I
phobias	I___I___I____I____I	social isolation	I___I___I____I____I	substance abuse	I___I___I____I____I
obsessions/compulsions	I___I___I____I____I	worthlessness	I___I___I____I____I	other (specify)	I___I___I____I____I

EMOTIONAL/PSYCHIATRIC HISTORY

____ ____ **Prior <u>outpatient</u> psychotherapy?**

No **Yes** If yes, on _____ occasions. Longest treatment by _____ for _____ sessions from _____/_____ to _____/_____

Prior provider name	City	State	Phone	Diagnosis Intervention Modality	Beneficial?

Provider Name Month/Year Month/Year

____ ____ **Has any family member had outpatient psychotherapy: If yes, who/why (list all):**

No Yes _____

_____

OLIVE BRANCH PSYCHOTHERAPY

Dr. Stephen R. Parrish DMFT, LCPC
1601 2nd Ave. North - Suite 514 (Columbus Center) Great Falls, Montana 59401; 406-217-2338

____ _____ **Prior inpatient treatment for psychiatric, emotional, or substance use disorder?**

No Yes If ye, on _____ occasions. Longest treatment at _____ from _____/_____ to _____/_____
Name of facility Month/Year Month/Year

Inpatient facility name	City	State	Phone	Diagnosis Intervention Modality	Beneficial?

____ ____ **Has any family member had inpatient treatment for psychiatric, emotional, or substance use disorder? If yes, who/why (list all):**

No Yes _____

_____

____ _____ **Prior or current psychotropic medication usage? If yes:**

No Yes Medication	Dosage	Frequency	start date	End date	Physician	Side effects	Beneficial?

____ ____ **Has any family member used psychotropic medications : If yes, who/why (list all):**

No Yes _____

_____