MICHIGAN STATE UNIVERSITY – DEPARTMENT OF PSYCHIATRY

GEROPSYCHIATRY

Patient Information Form

IDENTIFYING DATA:

Name _____ Age _____

Address _____

Telephone No.: _____

Guardian/Power of Attorney: _____

Reason for Seeking Treatment: _____

_____

_____

Referral Source: _____

PREVIOUS PSYCHIATRIC TREATMENT:

Date: _____

Type of Treatment: _____

_____

Date: _____

Type of Treatment: _____

_____

MEDICAL HISTORY:

Current Physician: _____

Address: _____

Current Medical Problems: _____

_____

_____

Name	Strength	Dosage Schedule

Current Medications: _____

_____

_____

_____

_____

_____

_____

_____

Past Surgeries: _____

_____

_____

DRUG & ALCOHOL USE:

History of Substance Abuse: _____

_____

Length of Time Substance Used: _____

_____

Amount Per Day: _____

_____

FAMILY HISTORY:

Mother's Name: _____

Quality of Relationship: _____

Year / Cause of Death: _____

Father's Name: _____

Quality of Relationship: _____

Year / Cause of Death: _____

Number of Brothers: _____ Sisters: _____

Names (Brothers): _____

Names (Sister): _____

Quality of Relationship: _____

Family History of
Psychiatric Illness: _____

_____

Family History
of Suicide: _____

_____

Family History of
Substance Abuse: _____

_____

MARITAL HISTORY:

Marital Status: M S D W SEP

Spouse Name: _____

Quality of Relationship: _____

Previous Marriages
(Relationships): _____

Quality of Relationship: _____

Children:	Names	Quality of Relationship
	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____

SOCIAL HISTORY:

Education Level: _____

Employment: _____

Military History: _____

Involvement With
Legal System: _____

Hobbies: _____

The Geriatric Depression Scale – short form (GDS)

Patient Name _____ Date _____

Choose the best answer for how you felt over the past week:

1. Are you basically satisfied with your life?	Yes/ No
2. Have you dropped many of your activities/interests?	Yes/No
3. Do you feel that your life is empty?	Yes/No
4. Do you often get bored?	Yes/No
5. Are you in good spirits most of the time?	Yes/No
6. Are you afraid that something bad is going to happen to you?	Yes/no
7. Do you feel happy most of the time?	Yes/No
8. Do you often feel helpless?	Yes/No
9. Do you prefer to stay home, rather than going out & doing new things	Yes/No
10. Do you feel you have more problems with memory than most people?	Yes/No
11. Do you think it is wonderful to be alive now?	Yes/No
12. Do you feel worthless the way you are now?	Yes/No
13. Do you feel full of energy?	Yes/No
14. Do you feel that your situation is hopeless?	Yes/No
15. Do you think that most people are better off than you?	Yes/No

Yesavage JA,Brink TL, Rose TL. Development and validation of a geriatric depression screening scale: A preliminary report, J Psychiatry Res 1982; 17:37-19.

Form date 7/2/99

MICHIGAN STATE UNIVERSITY

Department of Psychiatry

Patient Name _____ Date _____

Medicare law requires that we determine if your medical services might be covered by another insurer. To assist us in the correct billing of these services, please answer the following questions:

Are you currently working?

No _____

Yes _____

If married, is your spouse currently working?

No _____

Yes _____

If yes, are you covered by any health insurance your spouse may have?

No _____

Yes _____

Please present all insurance cards to receptionist. Thank you.