



The Asheville Project®

Patient History and Initial Assessment for Depression

Please fill out this form and bring with you to your first appointment with your pharmacist.

Patient Name: _____ Phone Number: _____

Date of Birth: _____ E-Mail Address _____

Primary Care Physician: _____ Phone Number: _____

Therapist: _____ Phone Number: _____

Allergies: _____

Past Medical History:

DO YOU HAVE, OR HAVE YOU EVER BEEN TOLD THAT YOU HAD:
(Circle)

- Yes No Heart disease (heart attack, angina, heart surgery, arrhythmia, congestive heart failure)
- Yes No Diabetes
- Yes No Lung disease
- Yes No High blood pressure
- Yes No Low potassium
- Yes No Thyroid problems
- Yes No Kidney problems
- Yes No Cancer
- Yes No Liver or gallbladder trouble
- Yes No Head trauma
- Yes No Osteoporosis
- Yes No Arthritis or Gout
- Yes No Stroke or TIA
- Yes No Migraine Headaches
- Yes No Seizures
- Yes No Anxiety disorder, panic attacks
- Yes No Depression
- Yes No Glaucoma, macular degeneration or other eye problem
- Yes No Other. Describe: _____
- Yes No Serious infections. Describe: _____

Current Medications (include over-the-counter medicines and herbal remedies):

<u>DRUG</u>	<u>DOSE</u>	<u>DIRECTIONS</u>	<u>PRESCRIBING DOCTOR</u>	<u>USED FOR?</u>	<u>STARTED WHEN ?</u>
<u>1</u>					
<u>2</u>					
<u>3</u>					
<u>4</u>					
<u>5</u>					

Have you ever had any problems with your medication (explain)?

Medication used in the past for depression:

Name of Medication	Reason Stopped

History of Depression:

Date initially diagnosed:		Length of treatment:	
Have you experienced periods since the date above when you were able to stop treatment/medication?			
Approximate Date Treatment Started	Medication (Name and dose)	Therapist (frequency)	Approximate Date Treatment Stopped
List any hospitalization(s) or ER visits for treatment of depression. <i>(Dates/reasons/duration/outcome)</i>		List any physician office visits related to your depression for the last 12 months. <i>(Date/reason/outcome)</i>	
Do you have a family history of depression or mental illness? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain.		Have you had electroconvulsive therapy (ECT) before? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when was last treatment?	

Do you feel like you have a high amount of stress in your life? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, how do you manage it?	Identify things in your life that cause you stress? (work, family, health, etc.)
Are you a member of any support groups or do you have ample support from friends and family? (explain)	
What activities do you engage in for relaxation?	
What activities/hobbies do you engage in for pleasure?	

Patient Health Questionnaire -9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several Day	More than half the days	Nearly every day
1. You have had little interest or pleasure in doing things.				
2. Feeling down, depressed, or hopeless				
3. Trouble falling or staying asleep, or sleeping too much				
4. Feeling tired or having little energy				
5. Poor appetite or overeating				
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down				
7. Trouble concentrating on things, such as reading the newspaper or watching television				
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				
9. Thoughts that you would be better off dead or of hurting yourself in some way				
SCORING FOR USE BY PROGRAM PERSONNEL ONLY	0	(total) x 1 = ____	(total) x 2 = ____	(total) x 3 = ____
	0	+ ____	+ ____	+ ____
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? (circle one)		= Total Score:		
Not difficult at all	Somewhat difficult	Very Difficult	Extremely Difficult	

Diet/Nutrition:

Current Height?	Current weight?
Any recent weight changes? (Describe)	Any recent changes in your appetite? (Describe)
Do you follow any special diet plan, such as a low-sodium diet?	Other diet plans previously followed <i>(Plan/Reason for termination)</i>
Do you drink alcoholic beverages? <input type="checkbox"/> No, I do not drink alcohol. <input type="checkbox"/> Yes, I drink no more than 7 drinks per week. <input type="checkbox"/> Yes, I drink more than 7 drinks per week.	

Exercise/Lifestyle:

Do you have a regular exercise schedule? <input type="checkbox"/> NO <input type="checkbox"/> YES <i>(Type and Frequency):</i>	
Are you exercising more or less than a year ago? <input type="checkbox"/> MORE <input type="checkbox"/> LESS <i>(Why?)</i>	What things keep you from exercising?
Do you smoke? <input type="checkbox"/> No, I have never smoked. <input type="checkbox"/> No, I am not a current smoker and I quit greater than 6 months ago. <input type="checkbox"/> No, I am not a current smoker and I quit within the past 6 months. <input type="checkbox"/> Yes, I currently smoke.	

Symptoms: Please check any symptoms you have experienced in the last 6 months and explain.

<input type="checkbox"/> Headache <input type="checkbox"/> Nasal congestion <input type="checkbox"/> Dry eyes and/or mouth <input type="checkbox"/> Loss of appetite <input type="checkbox"/> Change in taste	<i>How often, describe</i>
<input type="checkbox"/> Excessive thirst <input type="checkbox"/> Cough <input type="checkbox"/> Rash <input type="checkbox"/> Flushing <input type="checkbox"/> Sweating <input type="checkbox"/> Dizziness <input type="checkbox"/> Weakness <input type="checkbox"/> Rapid heart beat or palpitations	<i>How often, describe</i>
<input type="checkbox"/> Constipation	<i>How often, describe</i>

<input type="checkbox"/> Swelling of legs, fluid retention <input type="checkbox"/> Insomnia or agitation <input type="checkbox"/> Sedation or lethargy	
<input type="checkbox"/> Low blood pressure <input type="checkbox"/> Nausea or gastrointestinal effects <input type="checkbox"/> Balance problems <input type="checkbox"/> Sexual dysfunction <input type="checkbox"/> Weight gain	<i>How often, describe</i>

Depression Education:

Have you received any education about your depression? <input type="checkbox"/> NO <input type="checkbox"/> YES If yes, was the education provided by <input type="checkbox"/> Your physician <input type="checkbox"/> Written materials. Describe _____ <input type="checkbox"/> Self (internet, books or other). Describe _____ <input type="checkbox"/> Other. Describe _____
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Contact Information (optional):

Is there anyone who helps you with your care that you would permit release of medical information to? This information would be limited to the scope of care provided by your pharmacist.

Name of contact: _____

Relationship: _____

Phone: _____

I agree that information related to my care may be discussed with the above-named person. I understand that I may, at any time, withdraw this permission either verbally or in writing.

Patient Signature

Date

Witness

Date

In the event of an Emergency, contact:

Name: _____

Relationship: _____

Phone number: _____