SUMMIT RESEARCH NETWORK

This form should take about 10 minutes to complete.
Thanks in advance for completing it.

Confidential Research Patient Information

Name: First: _____ Middle Initial: _____ Last:_____ Date:_____

Age: _____ Date of Birth: _____

Gender (select): ☐ Male ☐ Female

Race (select): ☐ Caucasian ☐ African American ☐ Native American ☐ Asian/PacificIslander ☐ Hispanic/Latin ☐ Other:_____

Contact Numbers:
Primary:_____Secondary:_____Email:_____

Home Address:
Street: _____
City: _____ State: _____ Zip Code: _____
Length of Residence here:____ Who lives with you?_____

Person to notify in case of emergency:
Name: _____ Relationship: _____
Telephone number: _____

I. SYMPTOMS:
What are your symptoms / what bothers you most (in priority order)?

Please indicate how much each symptom bothers you:
(1=A little; 2=Moderate; 3=A lot; 4=Extremely, place number after the symptom)
1._____(___) 4._____(___) 7._____ (___)
2._____(___) 5._____(___) 8._____ (___)
3._____(___) 6._____(___) 9._____ (___)

Family History of mental health problems: ☐ **None** ☐ **Unknown**

Relationship	Diagnosis	Treatment	**Staff Comments**

II. OTHER SYMPTOMS: (select Yes or No)

		Comments (for staff use only)
1. There are weeks that I feel charged with energy and require almost no sleep.	**Yes** ☐ **No** ☐	
2. I have had anxiety attacks that come on me suddenly and unexpectedly	**Yes** ☐ **No** ☐	
3. I have a strong urge to repeat certain acts over and over.	**Yes** ☐ **No** ☐	
4. Disturbing thoughts come into my mind that I cannot get rid of.	**Yes** ☐ **No** ☐	
5. I sometimes have trouble controlling my anger.	**Yes** ☐ **No** ☐	
6. I have experienced a traumatic event and have distressing memories of the event.	**Yes** ☐ **No** ☐	
7. I periodically injure myself on purpose.	**Yes** ☐ **No** ☐	
8. I think about suicide or have made a suicide attempt.	**Yes** ☐ **No** ☐	
9. I am afraid of certain places, objects, or animals and go out of my way to avoid them.	**Yes** ☐ **No** ☐	
10. I get unusually fearful in social situations.	**Yes** ☐ **No** ☐	
11. As a child I was frequently in trouble for fighting, lying, stealing or skipping school.	**Yes** ☐ **No** ☐	
12. I have had an eating disorder	**Yes** ☐ **No** ☐	

III. PERSONAL HABITS:

Do you currently use tobacco? _____ How much per day? _____

How many alcoholic beverages do you consume in a typical week? _____

Are you willing to discontinue all alcohol use if you participate in a study? ☐ No ☐ Yes

When was the last time that you used recreational drugs (e.g. marijuana, cocaine, methamphetamine, etc.)? Please select:

last week	last month	last year	last 5 years	last 10 years	over 10 years	never
☐	☐	☐	☐	☐	☐	☐

IV. LEGAL HISTORY:

Are you currently involved in a legal dispute? No ☐ Yes ☐ If yes, please explain:

_____

Have you ever been arrested? No ☐ Yes ☐ If yes, please explain:

_____

V. EDUCATION AND WORK HISTORY:

Less than High School ☐ High School/GED ☐ Some college ☐ College Grad ☐

While attending school, what grades do/did you typically earn? ☐ A ☐ B ☐ C ☐ D ☐ F

Are you currently employed? ☐ Yes ☐ No Hours worked per week:
What is your job? _____ How long have you had this job? _____
How many jobs have you had in the last ten years? _____ Length of longest job:_____

Have you ever served in the military? ☐ Yes ☐ No What branch? When?

_____

VI. RELATIONSHIP HISTORY:

Please select all that apply: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Partnered

Do you have children? No ☐ Yes ☐ If yes: How many? _____

What are your most important relationships (family, friends, children, partners, etc.)?

_____
_____

Which relationships are most difficult for you?

_____
_____

Thank you for completing this confidential form. You will have the opportunity to discuss your answers when you meet with your doctor.

For staff use only: Date reviewed with clinician:_____
All entries in _____ink made by _____upon review with the patient

Medical History Questionnaire

Name:_____ **Date:** _____ **DOB:** _____

Please check yes or no for each condition listed below					
Condition	**Yes**	**No**	**Description / Comment**	**Start Date**	**Stop Date**
Ear, Nose, Throat Disease?	☐	☐			
Eye Disease?	☐	☐			
Thyroid Disease / Goiter?	☐	☐			
Heart Disease?	☐	☐			
High Blood Pressure?	☐	☐			
High Cholesterol?	☐	☐			
Lung Disease?	☐	☐			
Diabetes?	☐	☐			
Liver / Gallbladder Disease?	☐	☐			
Stomach / Intestinal Disease?	☐	☐			
Kidney / Bladder Disease?	☐	☐			
Prostate Disease?	☐	☐			
Breast Disease?	☐	☐			
Uterine / Ovarian/ Cervical Disease?	☐	☐			
Epilepsy / Seizures/ Stroke or TIA?	☐	☐			
Neurological Disease?	☐	☐			
Bone or Joint Disease?	☐	☐			
Skin Disease?	☐	☐			
Psychological Problems?	☐	☐			
Blood Disease?	☐	☐			
Cancer or Tumors?	☐	☐			
Current method of birth control?	☐	☐			
Other?	☐	☐			

Medical History Questionnaire

SURGERIES or HOSPITALIZATIONS: **None** ☐

Surgery / Hospitalization	Date	Reason
1.		
2.		
3.		
4.		
5.		
6.		
7.		

ALLERGIES: Please list all including environmental, food, & medication **None** ☐

Allergy	Reaction	Date Started	Date Ended
		_____	_____
		_____	_____
		_____	_____

MEDICATIONS: What over-the-counter or prescription medications, including vitamins and herbal preparations, have you taken in the last 3 months? **None:** ☐

	Dose	# Times / Day	Reason	Start Date	Stop Date	Cont'd?
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐

Reviewed by: **Date:**