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Adult Patient Background Information

Name _____ Age _____ Today's Date _____

Marital and Family Status:

Never Married _____ Living with someone since _____ Married since _____

Separated since _____ Divorced since _____ Widowed since _____

How many times have you been married? _____ Number of children _____

Sons' ages _____ Daughters' ages _____

Spouse / Partner: Name _____ Age _____ Occupation _____

Excluding yourself, who lives in your household? Spouse / Partner _____

Children (names, ages) _____

Stepchildren (names, ages) _____

Others (names, relationship) _____

Educational/Occupational Status: (Check all that apply)

Employed _____ Full-time _____ Occupation _____

Unemployed _____ Part-time _____ Employer _____

Student _____ On disability _____ School _____

Homemaker _____ Retired _____ Other _____

Health Status:

Current or chronic health problems: None ____ Yes (specify) _____

Medications currently taken: None ___ Yes (specify) _____

Mental Health Status:

Previous Counseling: None _____ Yes (dates, location, therapist) _____

Previous Hospitalizations for emotional or substance abuse problems:

None _____ Yes (dates, facility, reason) _____

History of medications taken for emotional or substance abuse problems:

None _____ Yes (medications, dates taken) _____

Which of the following are of concern to you at this time? (Check all that apply_

Emotional Health: Self _____ Other _____ Abuse/violence _____

Substance use/abuse: Self _____ Other _____ Health-Related _____

Suicide Risk: Self _____ Other _____ Work-Related _____

Marital/couple relationship _____ Children _____

Other family issues _____ Financial _____

Eating disorder _____ Legal issues _____

Other (specify) _____

Current substance use: (write # in blank: 0=no use; 1=occasional use; 2=moderate use; 3=heavy use; 4=addiction, loss of control; 5=currently in treatment)

Alcohol _____ Other drugs _____

Tobacco use: None _____ Yes (how much?) _____

Caffeine use: None _____ Yes (how much?) _____