Lawrence M Raines, III, MD
Adult & Addiction Psychiatry
Cary / Chapel Hill, North Carolina

PATIENT'S PERSONAL HISTORY

(To be completed by Patient, Reviewed by/with Treating Physician)

PATIENT NAME:_____ DATE OF BIRTH:_____ DATE:_____

SECTION A: DEMOGRAPHICS **Gender** ☐ Male ☐ Female

Marital Status
- ☐ Single/Never Married
- ☐ Married
- ☐ Divorced
- ☐ Widowed
- ☐ Co-habitation/Common Law
- ☐ Life Partner

Highest Educational Level Completed
- ☐ Did not complete high school (highest-grade _____)
- ☐ High School Graduate
- ☐ Received GED
- ☐ Associates Degree
- ☐ Completed Four-Year Degree (Specify_____)
- ☐ Other (Specify)_____)

Ethnicity
- ☐ African Descent / African American / Black
- ☐ European Descent / Caucasian / White
- ☐ Native American or Native Alaskan
- ☐ Asian/Oriental or Pacific Islander
- ☐ Hispanic/Latino/Spanish American
- ☐ Middle Eastern
- ☐ Other (Specify _____)

SECTION B: SUBSTANCE USE / ABUSE HISTORY

Presenting Problems: (check all that apply)
- ☐ Daily opiate use (specify drug(s) of choice :_____)
- ☐ Other drug or alcohol use
- ☐ Financial problems
- ☐ Legal
- ☐ No social activities
- ☐ Poor family relationships
- ☐ Medical issues
- ☐ Psychiatric issues
- ☐ Encouraged to seek help (specify by whom:_____)
- ☐ Lost Job due to drug use
- ☐ Other

Prior Treatment Programs

a. Methadone Program ☐ No ☐ Yes, how many times? _____ Date of the last time? _____
If yes, did you detox successfully? ☐ No ☐ Yes

b. Inpatient Program ☐ No ☐ Yes, how many times? _____ Date of the last time. _____
If yes, did you finish the program? ☐ No ☐ Yes

c. Outpatient Program ☐ No ☐ Yes, how many times? _____ Date of the last time? _____
If yes, did you finish the program? ☐ No ☐ Yes

Lawrence M. Raines, III, M.D. PATIENT LAST NAME:_____

PSYCHOSOCIAL HISTORY (Continued)

If Seeking BUPRENORPHINE/NALOXONE (SUBOXONE) TREATMENT: Expectations of Treatment (anticipated length of treatment) please check one:

- ☒ 30 days
- ☒ 6 months
- ☒ More than a year, less than 3 years
- ☒ Other_____
- ☒ 90 days
- ☒ 1 year
- ☒ Indefinite-no plans to TAPER in the near future
- ☒ Never intend to TAPER; want maintenance

SECTION C: MENTAL HEALTH / PSYCHIATRIC HISTORY

Have you ever been diagnosed or treated for a psychiatric disorder such as depression or anxiety?

☒ No (skip to section D) ☒ Yes (check all diagnoses that apply)

Diagnosis

- ☒ Depression
- ☒ Anxiety
- ☒ Panic Attacks
- ☒ PTSD (Post Traumatic Stress Disorder)
- ☒ Personality Disorder (Specify which one _____)
- ☒ Bipolar Disorder
- ☒ Substance Use Induced Mood Disorder
- ☒ OTHER_____

Are you currently under the care of a therapist, psychologist or psychiatrist?

☒ No ☒ Yes, Who? _____

Address:_____

Telephone:_____

What medications are you currently taking for the above condition?

Lawrence M. Raines, III, M.D. PATIENT LAST NAME:_____

PSYCHOSOCIAL HISTORY (Continued)

SECTION D: FAMILY HISTORY AND RELATIONSHIPS

Use the following scale when describing your relationship:

E= *Excellent*, very close and supportive **F**= *Fair*, some problems, sometimes good though

G=*Good*, used to be close before drug use **P**= *Poor*, strained relationships

Marital History/Children: (Note: Record N/A in "name" and/or Medical/SA/MH if none of these applies)

Relation	Name	Age	Relationship (E,G,F,P)	Medical/Substance Abuse/Mental Health problems
Ex: Spouse	**Betty**	**30**	**G**	**Bipolar, Heroin addiction**
Partner or Spouse				
Child				
Child				

Any family history of attempted or completed suicide?_____ If so, please explain the circumstances as well as you are aware of them.

Lawrence M. Raines, III, M.D. PATIENT LAST NAME:_____

PSYCHOSOCIAL HISTORY (Continued)

Family of Origin History

Relation	Name	Age	Relationship	Medical/Substance Abuse/Mental Health problems
Mother				
Father				
Step-parent				
Brother				
Sister				
Step-brother				
Step-sister				
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				

Other comments:

Lawrence M. Raines, III, M.D. PATIENT LAST NAME:_____

PSYCHOSOCIAL HISTORY (Continued)

SECTION E: EMPLOYMENT

Employment History/Present Employment: ☒ Not employed ☒ Currently employed ☒ Self-employed

Explain why not employed _____

_____

Name and Address of Employer of Current Employment	Years at this Job?

Position/Title/Type of Business _____

Years employed in this profession/line of work _____

If employed less than two years or if employed in more than one position, complete the following. If unemployed, complete the information for your most recent job.

Name and Address of Employer	Self-Employed	Years at this Job?

☐

Position/Title/Type of Business _____

Years employed in this profession/line of work _____

Do you have any special training, licenses, or certificates?

☒ No ☒ Yes, which ones? _____

SECTION F: FINANCIAL

Financial Situation (check all that apply)

- ☒ Live paycheck to paycheck
- ☒ Receive financial support from family (from _____)
- ☒ Have a checking account
- ☒ Have a savings account
- ☒ Have a retirement plan
- ☒ Have an extensive credit card debt
- ☒ Need the assistance of financial counselor
- ☒ Own/purchasing my own home
- ☒ Receive public assistance/disability (What type? _____)
- ☒ Other _____

Lawrence M. Raines, III, M.D. PATIENT LAST NAME:_____

PSYCHOSOCIAL HISTORY (Continued)

SECTION G: SOCIAL

Social/Recreational (Hobbies, talents, aptitudes):

Support System (check all that apply)

- ☒ Family is primary support system
- ☒ Church/Religious group
- ☒ 12 Step Support Group
- ☒ Fitness program or Sports Team
- ☒ Parenting Group
- ☒ Other support group (Please specify _____)
- ☒ Attend additional group/counseling program (i.e., CSB) (Specify _____)
- ☒ Private Therapist (Specify _____)
- ☒ Other _____)
- ☒ No support system

SECTION H: LEGAL STATUS

Dates	Charge	Convicted? Yes, No, Pending)	Outcome (probation/parole/time served)

Who is your probation or parole officer? _____

SECTION I: PERSONAL PERCEPTIONS

Patient is Strengths as Identified by Patient (which works for you):

- ☒ Articulate
- ☒ Business-Like
- ☒ Centered
- ☒ Considerate
- ☒ Creative
- ☒ Dynamic
- ☒ Energetic
- ☒ Enthusiastic
- ☒ Family Supportive
- ☒ Financially Stable
- ☒ Generous
- ☒ Goal Oriented
- ☒ Has Charisma
- ☒ Honest
- ☒ Intelligent
- ☒ Keeps Commitments
- ☒ Level Headed
- ☒ Patient
- ☒ Physically Attractive
- ☒ Physically Strong
- ☒ Self-Aware
- ☒ Self-Reliant
- ☒ Spiritual
- ☒ Other

Needs/Problems as Identified by Patient (that detract from your life):

- ☒ Anger Management
- ☒ Domestic Violence
- ☒ Lacking Motivation
- ☒ Legal Assistance

Lawrence M. Raines, III, M.D. PATIENT LAST NAME:_____

PSYCHOSOCIAL HISTORY (Continued)

- [x] Educational/Vocational Assistance
- [x] Employment
- [x] Financial Assistance
- [x] Grief Counseling
- [x] HIV/AIDS Counseling
- [x] Housing/Shelter
- [x] Illiterate/Needs to Read
- [x] Impulse Control
- [x] Insomnia
- [x] Other
- [x] Medical Attention
- [x] Psychiatric Help
- [x] Public Assistance
- [x] Refusal Skills
- [x] Social Support
- [x] Spiritual Support
- [x] Stress Reduction
- [x] Transportation
- [x] Values Clarification

Patient is Abilities as Identified by Patient (that enhances your effectiveness in your life):

- [x] Athletic
- [x] Auto Mechanic
- [x] Computer Literate
- [x] Employable/Always Works
- [x] Good Driver
- [x] Homemaking
- [x] Organized
- [x] Parenting Skills
- [x] Public Speaking
- [x] Skilled Trades
- [x] Social Skills
- [x] Thrifty
- [x] Other:

Previously Helpful Treatment Factors or Desired Treatment Factors:

- [x] Female Counselor
- [x] Male Counselor
- [x] 12 Step Approach
- [x] Spiritual Guidance
- [x] No Religious/Spiritual Preferences
- [x] Gay/Lesbian Counselor
- [x] Education Groups
- [x] Formerly Addicted Counselor
- [x] Counselor with no former addiction
- [x] Controlled usage over abstinence
- [x] No reading/written assignments
- [x] Deaf/Hearing/Sight Impaired Assistance
- [x] Barrier Free Accommodations
- [x] More intensive groups
- [x] More individual counseling
- [x] Other:

Lawrence M. Raines, III, M.D. PATIENT LAST NAME:_____

PSYCHOSOCIAL HISTORY (Continued)

SUBSTANCE USE / ABUSE HISTORY (Part 3)

Example:

16 Yrs Old	***Heroin***	***Daily***	***$ 100 / grams / bags, etc.***	***Oral/Smoke/Nasal / IV (intravenous)***	***today***

AGE STARTED USE	SUBSTANCE/ DRUG USED	HOW OFTEN used?	HOW MUCH per episode of use?	WHICH WAY BROUGHT INTO THE BODY?	LAST TIME USED?
	Alcohol				
	Clonidine/ Catapress® (BP medication)				
	Cocaine/Crack				
	Codeine				
	Dilaudid®				
	Ecstasy (MDMA)				
	Heroin				
	Hydrocodone / Oxycodone				
	Klonipin® (Clonazepam)				
	Marijuana				
	Methadone (pills / liquid)				
	Opium				
	Other Morphine				
	OxyContin®				
	Phenobarbital				
	Speed / Stimulants /Adderall® / Ritalin®				

Lawrence M. Raines, III, M.D. PATIENT LAST NAME:_____

PSYCHOSOCIAL HISTORY (Continued)

	Tylenol 3® (Codeine)				
	Valium® (Diazepam)				
	Xanax® (Alprazolam)				
	PCP/LSD/ MUSHROOMS				

Other Drugs/Medications

Other comments:

Lawrence M. Raines, III, M.D. PATIENT LAST NAME:_____

PSYCHOSOCIAL HISTORY (Continued)

MENTAL HEALTH OR SUBSTANCE ABUSE TREATMENT HISTORY

Previous behavioral health services:

Type of Program	If yes, when, where, and diagnosis?
☒ Methadone Treatment	_____
☒ Intensive Outpatient (IOP)	_____
☒ Psychiatry	
_____	
☒ Counselor/Mental Health Therapist	_____
☒ Inpatient Program	_____
☒ County CSB	_____
☒ Detox Program_____	_____
☒ Hospitalization_____	_____
☒ Other _____	

Comments

_____

_____

_____

Efficacy of current medications or previous medications:

Current (C) or Previous (P)	Name of Medication	Diagnosis	EFFECTIVE? YES/NO

Relationships/Sexual Preference: (check all that apply)

☒ Monogamous	☒ Currently Abstinent
☒ Currently involved Sexual Relationship	☒ Multiple Partners (past year)
☒ Opposite Sex Partner Preferred	☒ Same Sex Partner Preferred
☒ Bi-Sexual	☒ Transsexual
☒ Transgender	☒ Other _____

Spirituality/Religious Beliefs: ☒ Active ☒ Inactive Religion _____

☒ God ☒ Higher Power ☒ Agnostic ☒ Other _____

Method of Spiritual Participation

☒ Attends Services	☒ Listens to TV/Radio
☒ Private Meditation	☒ Prayer Group
☒ Visits from Spiritual Leader	☒ Other _____

Spiritual Needs

☒ Books	☒ Symbols
☒ Articles	☒ Diet
☒ Medical Concerns	☒ Other

Lawrence M. Raines, III, M.D. PATIENT LAST NAME:_____

PSYCHOSOCIAL HISTORY (Continued)

Signs of Distress You Tend to Express

- ☒ Crying
- ☒ Sleep Disturbance
- ☒ Feeling remote/removed from God
- ☒ Anger toward family/God
- ☒ Loss of hope
- ☒ Expressions of Guilt
- ☒ Disrupted Spiritual Trust
- ☒ Moderate to severe anxiety
- ☒ Loss of meaning in life

Comments regarding spirituality/religious beliefs:

History of Abuse: ☒ None stated ☒ Victim ☒ Perpetrator

Type of Abuse: ☒ Emotional Abuse ☒ Physical Abuse ☒ Sexual Abuse

If abused, by whom OR whom did you abuse?

- ☒ Parent
- ☒ Other Relative
- ☒ Child
- ☒ Partner/Spouse
- ☒ Stranger
- ☒ Other _____

Comments regarding abuse:

Risk-Taking Behaviors (currently or in the last 10 years):

- ☒ Criminal behavior
- ☒ Sharing Needles
- ☒ Driving intoxicated/Under influence
- ☒ Driving without a license
- ☒ Speeding/Reckless Driving
- ☒ Binge Eating/Purging
- ☒ Avoid forming social relationships
- ☒ Perfectionist
- ☒ Fails to obtain appropriate medical care
- ☒ Unprotected Sex
- ☒ Frequenting High Crime Areas
- ☒ Unstable/violent relationship
- ☒ Excessive spending
- ☒ Avoid addressing financial issues
- ☒ Seductive/Provocative Behavior
- ☒ Workaholic
- ☒ Failure to provide for children
- ☒ Frequenting bars

Other risk-taking behaviors:

Lawrence M. Raines, III, M.D. PATIENT LAST NAME:_____

PSYCHOSOCIAL HISTORY (Continued)

Problems as Identified by **Patient** (which work against treatment):

Patient's Assets as Identified by **Patient** (helpful to treatment):

_____ _____

Patient's Signature Date Physician Signature Date

_____ Lawrence M. Raines, III, M.D.

PATIENT'S PRINTED NAME

PERSONAL PERSPECTIVE

To be completed by Family Member or Friend

Patient Name _____

Any information you would like our staff to know about the patient that may help in their treatment:

Problems as Identified by Friend/Family Member (which work against the patient)

Patient's Assets as Identified by Friend/Family Member (which work for patient)

Lawrence M. Raines, III, M.D. PATIENT LAST NAME:_____

PSYCHOSOCIAL HISTORY (Continued)

Any additional information thought to be helpful:

Relationship to patient _____

Completed by _____ Date _____

Our Staff thanks you for your input. You may return this form by fax, mail, or simply giving it to the patient to give to us.