**OCD History Form**

|  |
| --- |
| **Name:**  |
| **Age:**  | **Date of Birth:**  |
| **Referring Psychiatrist:**  |
| **Age of Symptom Onset:**  | **Age of OCD Diagnosis:**  |
| **Year of Symptom Onset:**  | **Year of OCD Diagnosis:**  |
| **YBOCS Score:** | **YBOCS date completed:**  |
| **Education Level:**  | **Handedness: □ Right □ Left □ Ambidextrous** |
| **Characteristics of OCD:**  |
| **Co-Morbidities**  |
| **Psychosis**: **□** Schizophrenia**□** Schizoaffective Disorder**□** Delusional Disorder **□** Other | **Anxiety**: **□** Panic **□** Phobia **□** Generalized **□** OCD **□** Social Phobia**□** PTSD |
| **OC Spectrum:****□** Tourette Syndrome**□** Body Dysmorphic Disorder**□** Trichtillomania/Dermatillomania**□** Eating Disorder**□** ADHD | **Seizures: □** Yes□ No**ETOH/Substance Abuse: □** Yes □ No **□** Ever **□** CurrentlyIf patient ever or currently abused, what and when?**Personality Disorder: □** Yes **□** NoIf Yes, describe:  |
| **Other Psychiatric Diagnoses:** |
| **Past Psychiatric/Medical History** |
| Number of Psychiatric hospitalizations: | History of involuntary hospitalization: **□** Yes □ No |
| Suicide Attempts: **□** Yes □ NoHow many?Methods: | Dates of psychiatric hospitalizations:  |
| **Additional Medical History:** |
| **Allergies:**  |
| **Surgical History:** |
| **Social History:** **Single Married Divorced Children Lives with: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Occupation:****Hobbies:****Guns in the home: Yes No****History of legal problems:** **Tobacco: □ Yes □ No**. If yes, how many packs? \_\_\_\_\_ How many years?\_\_\_\_\_\_**Alcohol: □ Yes □ No**. If yes, how much (glasses, cans, shots)? \_\_\_\_\_ Type?\_\_\_\_\_\_\_\_\_\_\_\_\_**Illicit Drugs: □ Yes □ No**. If yes, what? \_\_\_\_\_\_\_\_\_\_\_\_\_**Caregiver/Social Issues:**  |
| **Family Medical History:****Family History of Psychiatric Disorders:** |
| **Current Medications** | **Dose** | **Frequency** | **Effects/Response** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| **Psychiatric Treatment History** |
| **Psychotherapy Tried (include provider, type, and approx. # of sessions):** |
| **Somatic Therapies:****ECT (Response +/-)**Bilateral:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Unilateral:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Transcranial magnetic Stimulation**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Prior psychiatric neurosurgical treatments**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Intravenous clomipramine**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Ketamine (IV):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Date:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Ketamine (intranasal)**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Notes: |

|  |
| --- |
| **Medication History** |
| **Serotonergic Medications** | **Total Duration** | **Maximum Dose** | **Maximum Dose Duration** | **Dates** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| **Benzodiazepines** | **Total Duration** | **Maximum Dose** | **Maximum Dose Duration** | **Dates** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| **Antipsychotics** | **Total Duration** | **Maximum Dose** | **Maximum Dose Duration** | **Dates** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| **Other Augmenting Agents** | **Total Duration** | **Maximum Dose** | **Maximum Dose Duration** | **Dates** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referring Psychiatrist Signature Printed Name Date