NAME: _____ **DOB:**_____ **DATE:**_____

PSYCHIATRIC & MEDICAL HISTORY

PRESENTING PROBLEM_____

PSYCHIATRIC HISTORY: If "YES" is checked, please briefly explain

Prior Psychiatric treatment ☐NO ☐ YES Diagnosis_____

_____

In patient hospitalization ☐NO ☐ YES _____

Suicide Attempt ☐NO ☐ YES _____

Therapist ☐NO ☐ YES Name:_____

Psychiatrist: ☐NO ☐ YES _____

CURRENT PSYCHIATRIC MEDICATIONS Prescription ☐ NO ☐ YES

_____

_____

CURRENT NON-PSYCHIATRIC MEDICATIONS:_____

_____

_____

OTC/Herbs ☐ NO ☐ YES _____

PLEASE CHECK ANY OF THE FOLLOWING MEDICATIONS PREVIOUSLY TAKEN OR FAILED:

Antidepressant: ☐ Prozac ☐ Paxil ☐ Zoloft ☐ Celexa ☐ Lexapro ☐ Effexor ☐ Wellbutrin ☐ Remeron ☐ Serzone ☐ Cymbalta ☐ TCA ☐ MAOI ☐ Other _____

Antipsychotic: ☐ Risperdal ☐ Zyprexa ☐ Seroquel ☐ Geodon ☐ Abilify☐ Haldol ☐ Prolixin ☐ Other

Mood stabilizer: ☐ Lithium ☐ Depakote ☐ Tegretol ☐ Trileptal ☐ Lamictal ☐ Topamax ☐ Gabitril ☐ Other

Hypnotic: ☐ Trazodone ☐ Benadryl ☐ Ambien ☐ Sonata ☐ Restoril ☐Halcyon ☐ Other

Stimulant: ☐ Ritalin ☐ Adderal ☐ Concerta ☐ Strattera ☐ Other

Anxiolytics: ☐ Xanax ☐ Ativan ☐ Klonopin ☐ Valium ☐ Buspar ☐ Vistaril ☐ Benadryl ☐ Other

Other: _____

CHEMICAL DEPENDENCY HISTORY: Ever used any drugs and/or alcohol ☐NO ☐ YES

1=experimented 2=used previously 3=actively using

__Alcohol	__Inhalants	__Mushrooms	__ Ecstasy	__ Prescription benzos	__Nicotine
__Marijuana	__PCP	__ Amphetamines	__ Methadone	__ Prescription Opioids	
__Cocaine	__LSD	__ Heroin	__ other	__ Prescription other	

Ever stopped using? ☐ YES ☐ NO Longest time of abstinence _____Most recent relapse ☐ Yes ☐ No ____

Rehab ☐ Yes ☐ No Half way House ☐ Yes ☐ No AA/NA meetings ☐ Yes ☐ No Sponsor ☐ Yes

RELEVANT MEDICAL HISTORY& MEDICATIONS

Weight ☐ loss ☐ gain _____ pounds in _____weeks/months trying to: ☐ Gain ☐ Lose

Nutrition ☐ Binging ☐ Purging ☐ Laxative ☐ Special Diet

Sleep ☐ Continuous ☐ Interrupted ☐ Difficulty falling asleep ☐ Awaken frequently

hrs of sleep last night? _____

GYN Last period date_____ Are you currently pregnant? ☐ NO ☐YES Due date?_____

Contraceptive ☐NO ☐ YES

Please continue to back of page.

NAME:_____ **DOB:**_____**DATE:**_____

PSYCHIATRIC & MEDICAL HISTORY-continued

Respiratory □Asthma □ Chronic Obstructive Lung disease

Gastrointestinal □ Irritable bowel syndrome

Cardiovascular □Hypertension □ Heart disease

Sensory □ Visual deficit □ Hearing deficit □Other ***Neurological*** □Seizures □Stroke □ Head trauma

Endocrine □Diabetes Mellitus □ Hypothyroidism □ Hyperthyroidism □ Hyperlipidemia

Muscle/skeletal □ Chronic fatigue syndrome □ Fibromyalgia □Migraines □chronic pain _____

□Trauma _____

Disease/Illness: □Hepatitis □HIV □ Cancer_____

PCP: Name_____**Phone**_____**Fax**_____

ALLERGIES □ No Known Drug Allergies □ Penicillin □ Sulfa □ Other _____

PERSONAL/ SOCIAL HISTORY

Childhood History: Parent/Caregiver: □ Mother □ Father □ Step □ Grandparents □ Family □ Foster □ Adopted

_____

_____

_____

FAMILY HISTORY: (state age, cause of death, any mental or major medical illness)

Maternal Grandmother_____Maternal Grandfather_____

Paternal Grandmother_____Paternal Grandfather_____

Mother _____Father_____

Siblings: _____

_____

Other family with mental illness_____

Marital status □ Single □Widowed □Divorced □Separated □Girlfriend □Boyfriend □Married □Engaged

Children: □ None □ Own □ Step

Age/sex:_____

_____

Support System □ None □Family □Friends □Church □Sponsor □ other _____

Living at: □House □Apartment □Assisted Living Live with: □Alone □Significant Other □Family □Friends

Education: □Elementary □HS □Some College □AA □BS □ MS □Doctorate

Learning Disabilities: □ NO □ YES_____

Occupation: □Disabled □Retired □Unemployed □Employed at_____

Finances: □ No issues □ Behind in paying bills □ Bankruptcy □ shopping sprees

Sexual History: □Inactive □ Sexually active with □Male □Female □Both; □ Monogamy □ Multiple partners

Abuse History: □NO □YES □Sexual □ Physical □ Emotional

_____

Legal History □ No □ Yes

□ Incarceration □ Arrests □ Probation □ Pending Law Suits/ Legal Actions □ DUI □ CPS/APS reports

Name _____Signature _____