**Adult Mental Health History Form**

Please complete this form and either fax to 888-262-4895 or email (copy/paste or as an attachment) to info@nellpeiken.com.

**Please note that I require that clients be currently engaged in psychotherapy.**

If you have any questions about this form please email me at the address above or call/text me at 978-406-9043.

Nell Peiken, Psychiatric Mental Health Nurse Practitioner

Name:

Date of Birth:

Phone number:

E-mail address:

Health Insurance:

What issue(s) have led you to seek a medication evaluation? What is your psychiatric diagnosis (if known)?

How long have you been seeing your current therapist?

How frequent are the visits?

Have you ever been treated by a psychiatrist or psychiatric nurse prescriber?

If so, what led you to end treatment with this provider?

Are you currently taking any psychiatric medication(s)?

If so, please list the medication(s) you are currently taking as well as when each medication was first prescribed.

Have you taken any psychiatric medications in the past that you are no longer taking?

If so, please list the medication(s) and indicate when it was first prescribed and what led you to stop taking this medication.

Does you have a history of self-harming behaviors or suicidal thoughts?

If so, please describe.

Have you ever been to an emergency room for a psychiatric evaluation?

If so, what was the outcome of this/these evaluation(s)?

Have you ever been in a psychiatric hospital?

If so, what were the (approximate) dates of the hospitalization(s)?

What led up to this/these hospitalization(s)?

Have you ever had a problem with drug or alcohol use?

If so, what treatment, if any, have you had?

Have you ever engaged in disordered eating (binging/purging/restricting)?

If so, what treatment, if any, have you had? Please note that I require all clients with eating disorders to be in treatment with a registered dietitian and a primary care provider as well as a therapist.

Have you ever been assaultive toward others? If so, please describe.

Are there any other safety concerns?

Are you currently being treated for a medical condition?

What non-psychiatric medications, if any, are you currently taking?

Have you ever seen a medical specialist?

If so, what diagnosis was given and what treatment was required?

Have you ever been diagnosed with a developmental or learning disability?

If so, what kind of accommodations have you required?

Thank you very much for completing the form. Once I receive it I will contact you shortly.