PORTABLE TREATMENT RECORD

Name: _____ **Date of birth:** _____

Strengths

- _____
- _____
- _____

Supportive people/relationships

- _____
- _____
- _____

Coping strategies

- _____
- _____
- _____

Hobbies and interests

- _____
- _____
- _____

Emergency contacts

Name _____ Phone: _____

_____

Relationship _____

Name _____ Phone: _____

_____

Relationship _____

Primary care physician

Name: _____ Phone: _____

Office address: _____

_____

Psychiatrist

Name: _____ Phone: _____

Office address: _____

_____

Other mental health professionals (therapist, case manager, psychologist, etc.)

Name: _____ Phone: _____

Office address: _____

_____

Type of mental health professional: _____

Name: _____ Phone: _____

Office address: _____

Type of mental health professional: _____

Name: _____ Phone: _____

Office address: _____

_____

Type of mental health professional: _____

Pharmacy

_____ Phone: _____

MEDICAL HISTORY

Allergies

Medication/ Food/Latex/Etc.	Reaction

Psychiatric medications that caused severe side effects

Medication	Side Effects	Approximate Date Discontinued

Major medical illnesses/injuries

Illness	Treatment	Current Status

Major medical procedures (ex: surgeries, MRI, CT scan)

Date	Procedure	Result

CURRENT MEDICAL INFORMATION

Diagnoses

Diagnosis	Diagnosed By	Date of Diagnosis

Psychiatric hospitalizations

Date of Admission	Reason for Hospitalization	Name of Facility	Date of Discharge

CURRENT MEDICAL INFORMATION

Current medication record

Date Prescribed	Physician	Medication	Dosage

Past medication record

Date Prescribed	Physician	Medication	Dosage	Date Discontinued