Psychological Solutions of Lake Norman, PLLC
ADULT PATIENT HISTORY FORM

Today's Date: _____

Patient's Name: _____

Please describe your medical diagnoses: _____

_____

_____

_____

Please list your current prescription and over-the-counter medications and supplements.

_____ Dose_____ Frequency/Schedule_____
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(Use back of paper or an attached page for medication list if needed)

Have you ever had any of the following: **Where? When? Why?**

____ CT, MRI, PET scan or other imaging of brain: _____
_____

____ Most recent hospitalization: _____
_____

____ Neuropsychological or Psychological Evaluation: _____
_____

____ Psychological Counseling/Psychotherapy: _____
_____

Please list your Current Providers:

- Primary Care/Internal Medicine: _____
- Neurologist: _____
- Cardiologist: _____
- Psychiatrist: _____
- Mental Health Counselor/Psychologist: _____
- Other: _____

Referral Source for Current Evaluation: _____

Current Concerns / In what way do you hope this evaluation will help you?_____

_____

_____

_____

Continued list of current prescription and over-the-counter medications and supplements.

____ Dose______________ Frequency/Schedule___________
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