CLAYTOR MEMORIAL CLINIC

1127 2nd Street, SW
Roanoke, VA 24016
Phone: 540-400-7495
Fax: 877-803-9136

10401 Warwick Blvd.
Newport News, VA 23601
757-782-2643
877-803-9136

admin@claytorclinic.com
www.claytormemorialclinic.com

Adult Psychiatric Background Information

PATIENT NAME: **DOB:** **SEX AT BIRTH: Female / Male**

PSYCHIATRIC HISTORY / INFORMATION

Briefly state the reason the patient would like to see a Psychiatrist/Psychiatric Physician Assoc. When did these symptoms begin?	

Primary Care Physician:	Facility:	Phone Number:
Previous Psychiatrist:	Facility:	Phone Number:
Is the patient presently taking prescription medications?		Yes No

If yes, please list them below:

Current Psychiatric Medications:	Dosage:	How long has the patient taken it:	Prescribing Doctor:
Previous Psychiatric Medications:			

Height:	Weight:	When was the patient's last medical exam?
Has the patient previously been treated by a psychiatrist? Yes No	If so, when?	Briefly describe the reason:
Has the patient previously been treated by a Therapist? Yes No	If so, when?	Briefly describe the reason:

Has the patient previously been hospitalized for psychiatric reasons? Yes No	If so, when?	Briefly describe the reason:

LEGAL HISTORY

Has the patient ever been involved with the police or juvenile court system? Yes No

If yes, please explain?

Has the patient ever had legal charges? Yes No

If yes, please explain?

FAMILY HISTORY / INFORMATION

List all persons currently residing in the patient's home:	Name:	Age:	Relationship to patient:

Does the patient have any children? Yes No
If yes please list their names below:

Name of child:	Age:	Where does the child live:

Family history *diagnosed by a physician*, Please check all that apply:

	FATHER	MOTHER	SIBLINGS	OTHER RELATIVES
Alcoholism				
Drug Abuse				
Depression				
Manic Depression				
Anxiety				
Suicide				
ADHD				
Obsessive/Compulsive Disorder				
Eating Disorder				
Other Psychiatric Disorders				
High/Low Blood Pressure				
Seizures				
Thyroid issues				
Diabetes				
Meningitis				
Heart Murmur				

Does the patient have a history of physical, verbal, or sexual abuse? Yes No

If yes, please explain:

SCHOOL/OCCUPATION HISTORY

What is the highest level of education attained? List any degrees or certifications held:

Has the patient had any academic difficulties? Yes No
If yes, please explain:

Is the patient currently attending school? Yes No
If yes, please list name of school and program of study:

Is the patient currently employed/working? Yes No
If yes, list name of employer and occupation and length of time at current job:

Has the patient held been employed/worked in the past? Yes No
If so, list previous employers and types of work done:

SUBSTANCE ABUSE HISTORY

SUBSTANCE	History of use?		Age of first use:	Date of last use:	Use within the past year?	
Alcohol	Yes	No			Yes	No
Barbiturates	Yes	No			Yes	No
Xanax, Valium, Librium	Yes	No			Yes	No
Cocaine, Crack	Yes	No			Yes	No
Heroin, Opiates	Yes	No			Yes	No
Marijuana	Yes	No			Yes	No
PCP, LSD, Mescaline	Yes	No			Yes	No
Inhalants	Yes	No			Yes	No
Caffeine	Yes	No			Yes	No
Nicotine	Yes	No			Yes	No
Amphetamines, Speed, Uppers, Crystal Meth	Yes	No			Yes	No
Designer Drugs, Ecstacy	Yes	No			Yes	No
Over-the-counter medications/supplements	Yes	No			Yes	No

Has the patient ever received substance abuse treatment? Yes No
If yes, please provide name of facility/facilities and outcome:

Cont. on next page

MEDICAL HISTORY

Has the patient ever had: Blackouts DUI Tremors Hallucinations

Please circle all that apply to the patient and list any additional medical history:

Mumps Measles Chicken Pox Seizures Asthma Heart Murmur Thyroid

High Blood Pressure Bowel or Bladder issues Diabetes Flu Chronic Pain

Please list all surgeries:

Other_____

ALLERGIES TO MEDICATIONS:

Is there anything else you would like your doctor to be aware of?

To be signed by person completing form:

_____

Print Name (Full Name)

_____ _____

Signature (Full Name) Date