Psychiatric and Medical History

Client Name: _____ Date: _____

Current Psychiatrist / Physician Managing Psychiatric Medications:

Name of Provider: _____

Address of Provider: _____

Phone # of Provider: _____

Condition(s) Treated: _____

Diagnosis History

Please list any past or current physical or psychiatric diagnoses: _____

_____

_____

Family History

Please list any relevant family psychiatric diagnoses: _____

_____

_____

Current Medications

Medication Name	Purpose	Dose	Time of Day Taken (AM/PM/3x Day/As Needed)	Do You Miss Doses?