INSIGHT

PSYCHIATRY

Patient History Form

Date: _____

Demographics

Patient name: _____

Date of Birth:_____Gender:_____

Address:_____

Phone:_____ Email:_____

Occupation: _____Employer:_____

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed ❑ Cohabitating

Current living situation: ❑ Alone ❑ with Spouse/Partner ❑ with Parents ❑ Other

Children: ❑ None Names & Ages:

_____

Emergency contact

Name: _____Relationship:_____

Address: _____Phone:_____

Provider Contacts

Primary Care Provider:_____Phone:_____

Psychiatrist: _____Phone: _____

Therapist: _____ Phone:_____

Pharmacy: _____Phone_____

Pharmacy address:_____

Referred by:_____

Mental Health History

Reason for Consultation:_____

_____

Goals for Treatment:_____

_____

Approximately when did your current symptoms start? _____

Have you ever had psychiatric symptoms before? If so, when did they begin and please describe them:_____

_____

Have you ever received mental health treatment before? ❑ Yes ❑ No

If so, please list your past outpatient (clinic) treatment:

Provider (name and profession)	Dates	Reason for Treatment	Type of Treatment (medications, therapy, both

Please list any inpatient (hospital) treatment:

Hospital	Dates	Reason for Treatment

Do you have a history of suicide attempt(s)? ❑ yes ❑ no

If so, please state when and by what means:_____

Substance Use History

Do you currently use alcohol? ❑ Yes ❑ No If so, how much: _____ drinks per ❑ day ❑ week ❑ month

Do you currently use any of the following drugs? ❑ Opiates (prescription and illicit) ❑ Cocaine ❑ Marijuana ❑ Amphetamines (prescription and illicit) ❑ LSD ❑ Ecstacy (MDMA) ❑ Other: _____

If so, how frequently do you use? _____

Have you ever been to any substance use treatment? ❑ Yes ❑ No

If so, what type(s) of treatment? ❑ 12-steps ❑ Detox ❑ Outpatient rehab ❑ Inpatient rehab ❑ Other:_____

Medication History

Please list all medications you are currently taking, or provide a list:

Medication	Dose	Frequency	Prescriber

If you have taken psychiatric medications previously, please list them with the following details to the best of your recollection:

Medication	Dates taken	Effectiveness	Side effects	Reason for stopping

Do you have any allergies to medications? ❑ Yes ❑ No

Please list and describe:_____

Medical History

Please list any medical conditions:_____

_____

_____

Surgeries: _____

Do you use tobacco? Y N How much? ____pack/day

Family & Social History

Does anyone in your family have a psychiatric condition or substance use problem that you know about? ❑ Yes ❑ No

If so, please list the family member and diagnosis including substance use (if known):

Family member	Diagnosis

What is your highest level of education? ❑ some high school ❑ graduated high school ❑ GED ❑ some college ❑ graduated college ❑ advanced degree

Who raised you growing up and who lived in the home (siblings, grandparents, etc)?

_____

Did you ever have to live outside of your family home? If so, with whom (ex. foster family, grandparents, group home, etc): _____

Do you feel that at any point in your life you were the victim of abuse? ❑ yes ❑ no

If so, in what way: ❑ physical ❑ sexual ❑ emotional ❑ verbally ❑ neglect

Have you ever been arrested? ❑ yes ❑ no

Were you ever convicted of a crime? ❑ yes ❑ no If so, please describe:

_____