Phone:
Fax:

Initial History Form

Please complete this form to the best of your abilities.
Your responses will provide us with information that will help us get to know you, your health and psychosocial history. We are particularly concerned about characteristics or experiences that can affect thinking and feelings. Please answer the questions honestly. Information will be kept confidential as indicated in our privacy notice. We will review this form with you, and you will have a chance to discuss your answers and clarify any questions. Thank you!

Primary Care Provider

Medications - List Current prescription medications

Illness, Injuries, Operations, Treatments

Weight (lbs) **Height (inches)**

Allergies

Are you currently in therapy, if so with who?

Previous Psychiatric/Mental Health Treatment

Phone:
Fax:

Initial History Form - 1/2/2026

Behavioral Medication History

Family Psychiatric History

How would you describe your childhood?

Relationship Status

Who do you currently reside with?

Highest Level of Education

Currently employed or student

Phone:
Fax:

Initial History Form - 1/2/2026

Military Status

Legal Issues

Who do you identify as your support network

Smoking Status

Alcohol Use

Caffeine Use

Substance Use