Patient History Information

Please complete the following form, telling us a bit about your medical history.
Fields marked with an * are required
Date *
Full Name *
Date of Birth *
Please select your date of birth or simply type it in as MM/DD/YYYY
Address *
City *
State *

Alabama Alaska Hawaii Idaho Illinois Indiana Iowa Kansas Kentucky Louisiana Maine Maryland
Arizona Massachusetts Michigan Minnesota Mississippi Missouri Montana Nebraska Nevada
New Hampshire New Jersey Arkansas New Mexico New York North Carolina
North Dakota Ohio Oklahoma Oregon Pennsylvania Rhode Island South Carolina California South
Dakota Tennessee Texas Utah Vermont Virginia Washington West
Virginia Wisconsin Wyoming Colorado ARMED FORCES AFRICA \ CANADA \ EUROPE \ MIDDLE
EAST ARMED FORCES AMERICA (EXCEPT CANADA) ARMED FORCES
PACIFIC Connecticut Delaware Florida Georgia
Zip *
Country *
- Select Country - Afghanistan Albania Algeria American
Samoa Andorra Angola Anguilla Antarctica Antigua And
Barbuda Argentina Armenia Aruba Australia Austria Azerbaijan Bahamas Bahrain Bangladesh Barbado
s Belarus Belgium Belize Benin Bermuda Bhutan Bolivia Bosnia And Herzegowina Botswana Bouvet
Island Brazil British Indian Ocean Territory Brunei Darussalam Bulgaria Burkina
Faso Burundi Cambodia Cameroon Canada Cape Verde Cayman Islands Central African
Republic Chad Chile China Christmas Island Cocos (Keeling) Islands Colombia Comoros Congo Congo,
The Democratic Republic Of The Cook Islands Costa Rica Cote D'Ivoire Croatia (Local Name:
Hrvatska) Cuba Cyprus Czech Republic Denmark Djibouti Dominica Dominican
Republic Ecuador Egypt El Salvador Equatorial Guinea Eritrea Estonia Ethiopia Falkland Islands
(Malvinas) Faroe Islands Fiji Finland France France, Metropolitan French Guiana French
Polynesia French Southern
Territories Gabon Gambia Georgia Germany Ghana Gibraltar Greece Greenland Grenada Guadeloupe
Guam Guatemala Guinea Guinea-Bissau Guyana Haiti Heard And Mc Donald Islands Holy See (Vatican
City State) Honduras Hong Kong Hungary Iceland India Indonesia Iran (Islamic Republic
Of) Iraq Ireland Israel Italy Jamaica Japan Jordan Kazakhstan Kenya Kiribati Korea, Democratic
People's Republic Of Korea, Republic Of Kuwait Kyrgyzstan Lao People's Democratic
Republic Latvia Lebanon Lesotho Liberia Libyan Arab
Jamahiriya Liechtenstein Lithuania Luxembourg Macau Macedonia, Former Yugoslav Republic
Of Madagascar Malawi Malaysia Maldives Mali Malta Marshall
Islands Martinique Mauritania Mauritius Mayotte Mexico Micronesia, Federated States Of Moldova,
Republic
Of Monaco Mongolia Montenegro Montserrat Morocco Mozambique Myanmar Namibia Nauru Nepal

Netherlands Netherlands Antilles New Caledonia New Zealand Nicaragua Niger Nigeria Niue Norfolk Island Northern Mariana Islands Norway Oman Pakistan Palau Panama Papua New Guinea Paraguay Peru Philippines Pitcairn Poland Portugal Puerto Rico Qatar Reunion Romania Russian Federation Rwanda Saint Kitts And Nevis Saint Lucia Saint Vincent And The Grenadines Samoa San Marino Sao Tome And Principe Saudi Arabia Senegal Serbia Seychelles Sierra Leone Singapore Slovakia (Slovak Republic) Slovenia Solomon Islands Somalia South Africa South Georgia, South Sandwich Islands Spain Sri Lanka St. Helena St. Pierre And Miquelon Sudan Suriname Svalbard And Jan Mayen Islands Swaziland Sweden Switzerland Syrian Arab Republic Taiwan Tajikistan Tanzania, United Republic Of Thailand Timor-Leste (East Timor) Togo Tokelau Tonga Trinidad And Tobago Tunisia Turkey Turkmenistan Turks And Caicos Islands Tuvalu Uganda Ukraine United Arab Emirates United Kingdom United States United States Minor Outlying Islands Uruguay Uzbekistan Vanuatu Venezuela Viet Nam Virgin Islands (British) Virgin Islands (U.S.) Wallis And Futuna Islands Western Sahara Yemen Yugoslavia Zambia Zimbabwe

Home Phone *

Cell Phone

Age *

Sex *

__Male
__Female

Height & Weight *

Emergency Contact Full Name *

Emergency Contact Phone Number *

Referring Clinician Name *

Referring Clinician Phone Number *

Primary Clinician Name *

Primary Clinician Phone Number *

Therapist's Name

Therapist's Phone Number

Principal Psychiatric Diagnosis *

Other Psychiatric Diagnoses

Current Medications & Doses *

Please list the names, doses & frequency of all medications (including over-the-counter medications) you are currently taking.

Medications you have tried in the past but have since discontinued usage:

Do you currently suffer from suicidal thoughts? *

___Yes
___No

If so, how often?

Allergies & Adverse Reactions? *

Please describe all known allergies, as well as the adverse reactions they cause.

Medical Problems *

Please describe your current and past medical problems.

Surgical History *

Please list the dates and description of all past surgeries.

Any history of problems with anesthesia for you or anyone in your family? *

___Yes
___No

If so, please describe:
Emergency Room Visits? *
Please describe any emergency room admissions in the past 3 months.
History of difficult IV stick/blood draw? *
___Yes
___No

History of Substance Use

For each substance listed, please describe how much you use, how often you use it, when you used it last, and for how many years you have been using it?

Tobacco *
Alcohol *
Marijuana *
Cocaine *
Heroin *
Other

Review of Systems

Please check off the various symptoms you are experiencing for each bodily system.

General *

___Weight Loss/Gain
___Fatigue
___Fever or Chills
___Weakness
___Trouble Sleeping
___None

Skin *

___Rashes
___Lumps
___Itching
___Dryness
___Color Changes
___Hair & Nail Changes
___None

Head *

___Headache
___Head Injury
___Neck Pain
___None

Ears *

___Decreased Hearing
___Ringing in Ears

___Earache
___Drainage
___None

Eyes *

___Vision Loss/Changes
___Glasses/Contacts
___Pain
___Redness
___Blurry or Double Vision
___Flashing Lights
___Specks
___Glaucoma
___Cataracts
___None

Nose *

___Stuffiness
___Discharge
___Itching
___Hay Fever
___Nosebleeds
___Sinus Pain
___None

Throat *

___Bleeding
___Dentures
___Sore Tongue
___Dry Mouth
___Sore Throat
___Hoarseness
___Thrush
___Non-Healing Sores
___None

Neck *

___Lumps
___Swollen Glands
___Pain
___Stiffness
___None

Breasts *

___Breastfeeding
___None

Respiratory *

___Cough
___Sputum
___Coughing Up Blood
___Shortness of Breath
___Wheezing
___Painful Breathing
___None

Cardiovascular *

___Chest Pain/Discomfort
___Tightness
___Palpitations
___Shortness of Breath with Activity
___Difficulty Breathing Lying Down
___Swelling
___Sudden Awakening from Sleep with Shortness of Breath
___None

Gastrointestinal *

___Swallowing Difficulties
___Heartburn
___Change in Appetite
___Nausea
___Change in Bowel Habits
___Rectal Bleeding
___Constipation
___Diarrhea
___Yellow Eyes/Skin
___None

Urinary *

___Frequency
___Urgency
___Burning or Pain
___Blood in Urine
___Incontinence
___Change in Urinary Strength
___None

Vascular *

___Calf Pain with Walking
___Leg Cramping
___None

Musculoskeletal *

___Muscle/Joint Pain
___Stiffness

___Back Pain
___Redness of Joints
___Swelling of Joints
___Trauma
___None

Neurologic *

___Dizziness
___Fainting
___Seizures
___Weakness
___Numbness
___Tingling
___Tremor
___Stroke
___None

Hematologic *

___Ease of Bruising
___Ease of Bleeding
___None

Endocrine *

___Heat or Cold Intolerance
___Sweating
___Frequent Urination
___Thirst
___Change in Appetite
___None

Psychiatric *

___Anxiety
___PTSD
___Depression
___Memory Loss
___Mania
___Bipolar Disorder
___Postpartum Depression
___Major Depressive Disorder
___None