Patient History

Patient Name: _____ Date: _____

Occupation: _____ Educational Level: _____

Please review the following and check any *current* symptoms that pertain to you.

☐ Depressed Mood	☐ Inflated Self Esteem
☐ Sleep Problem	☐ Don't Seem to Need Sleep For Days
☐ Change in Appetite	☐ Racing Thoughts
☐ Decrease Interest	☐ Excessive Talking
☐ Decrease Energy	☐ Spending Spree
☐ Difficulty in Concentration	☐ Distractibility
☐ Guilt	☐ Impulsive Behavior
☐ Irritability	☐ Trying To Do Way Too Much
☐ Crying Spells	☐ See / Hear Things That May Not Be Real
☐ Excessive Worrying	☐ Suspect / Believe Things That May Not Be Real
☐ Often Tense / Keyed Up	☐ Can Not Stop Repetitive Thoughts
☐ Panic Attack	☐ Can Not Stop Repetitive Behavior
☐ Intrusive / Recurrent Memory of Past Time	☐ Hyper Vigilant

Past Psychiatric Treatment

Have you seen a psychiatrist in the past? ☐ No ☐ Yes

If yes, when and Psychiatrist's name: _____

Have you seen a therapist in the past? ☐ No ☐ Yes

If yes, when and Therapist's name: _____

Have you ever been hospitalized for psychiatric reasons? ☐ No ☐ Yes

If yes, when and where were you hospitalized? _____

Have you taken any psychiatric medications in the past? ☐ No ☐ Yes

If yes, what are the names of the medications? What were the benefits of taking it? Did you experience any side effects? _____

_____

_____

_____

Patient Name: _____

Tobacco / Alcohol / Drug Use

Do you use tobacco? ☐ No ☐ Yes

If yes, what is the amount and how often? _____

Do you drink alcohol? ☐ No ☐ Yes

If yes, what is the amount and how often? _____

Do you use illicit and/or prescription drugs (not prescribed to you)? ☐ No ☐ Yes

If yes, what are the names of the illicit and/or prescription drugs. What are the amounts and how often are they taken? _____

Medical History

Do you have a primary care physician? ☐ No ☐ Yes

If yes, what is your primary care physician's name? _____

Do you suffer from any of the following medical problems?

☐ Hypertension	☐ Hypertension	☐ Stomach Ulcers
☐ Cong. Heart Failure	☐ Diabetes	☐ Head Injury
☐ Heart Disease	☐ Endocrine (Other)	☐ Seizure
☐ Cardiac (Other)	☐ Asthma	☐ Stroke
☐ High Cholesterol	☐ Liver Disease	☐ Neurological (Other)
☐ Other Medical Problem (Explain):		

Please explain any family medical history _____

_____

_____

If any, please explain family psychiatric history _____

_____

_____

Patient Name: _____

Have you ever been hospitalized for medical reasons or had surgery? ☐ No ☐ Yes

If yes, please explain. _____

_____

_____

Medication

Please list all current medications and include all over the counter and herbal medications.

Medication	Dose	Frequency

Do you have allergies to medication and/or food? ☐ No ☐ Yes

Medication / Food	Reaction

Legal

Do you have any current or past legal problems? ☐ No ☐ Yes

If yes, please explain _____

_____

_____

_____ _____

Patient / Parent / Guardian Signature Date