Patient Name:_____

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PATIENT HISTORY FORM

Patient Name _____

We look forward to your visit with our office. We would appreciate your completing this form and bringing it with you to your first appointment. This information will facilitate routine questions and save time for more important discussions.

HOUSEHOLD MEMBERS

Name	Occupation / Grade	Age	Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Mother's Age: _____ If deceased, how old were you when they died? _____

Father's Age: _____ If deceased, how old were you when they died? _____

If your mother and father divorced, how old were you at the time? _____

Total number of times mother divorced: _____ Number of times father divorced: _____

If your mother and father did not raise you when you were young, who did? _____

Age of living brothers: _____ Age of living sisters: _____ I was child _____ in a family of _____ children.

Family members not living in the household (stepchildren, adult children, etc.):

Name	Age	Relationship	Location
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Patient Name:_____

Please list family member(s) who have (or had) emotional problems, psychiatric illness (including suicide) and/or difficulties with drug or alcohol abuse:

Family Member (relationship to you)	Problem	Ongoing/Resolved (list one)
_____	_____	_____
_____	_____	_____
_____	_____	_____

Describe the problems that causing you to seek help:

_____

_____

When did the problem(s) begin?

_____

_____

Have you ever seen a psychiatrist? ☐ Yes ☐ No

Have you ever had individual therapy? ☐ Yes ☐ No

Have you had in-patient hospitalization? ☐ Yes ☐ No

If yes, with whom and for how long were you treated?

_____

_____

What are your current mental health medications?

Medication	Dosage	Frequency	For What
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Patient Name:_____

Have you taken previous medications for your mental health (dosage, duration and response)?

Medication	Dosage	Duration	Response

Any other prescribed medication?

Medication	Dosage	Frequency	For What

Any over-the-counter medications, vitamins or other supplements?

Medication	Dosage	Frequency	For What

Have you had allergic reactions or other problems with medications? ☐ Yes ☐ No

If yes, please list the medications and the reaction or problem:

_____

_____

When did the problem(s) begin?

_____

_____

Have you ever seen a psychiatrist? ☐ Yes ☐ No

Have you ever had individual therapy? ☐ Yes ☐ No

Have you had in-patient hospitalization? ☐ Yes ☐ No

If yes, with whom and for how long were you treated?

_____

_____

Patient Name:_____

What are your current mental health medications?

Medication	Dosage	Frequency	For What

Have you taken previous medications for your mental health (dosage, duration and response)?

Medication	Dosage	Duration	Response

Any other prescribed medication?

Medication	Dosage	Frequency	For What

Any over-the-counter medications, vitamins or other supplements?

Medication	Dosage	Frequency	For What

Have you had allergic reactions or other problems with medications? ☐ Yes ☐ No

If yes, please list the medications and the reaction or problem:

_____

_____

What medical problems do you have? Do you have a history of head injury?

_____

_____

PatientName: _____

List type and dates of any medical hospitalizations and/or surgeries you have had:

_____

_____

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

If yes, please state when and cause:

_____

_____

Have you ever attempted suicide? ☐ Yes ☐ No

If yes, how? _____

When: _____

Treatment received: _____

Are you having thoughts of harming yourself or others such as your spouse or children? ☐ Yes ☐ No

How much caffeine do you have a day? _____

Do you smoke? ☐ Yes ☐ No

How many cigarettes per day? _____

Have you ever had problems with drinking alcohol? ☐ Yes ☐ No

Do you desire to cut down use? ☐ Yes ☐ No

Have others been annoyed at your use? ☐ Yes ☐ No

Do you have guilt about use? ☐ Yes ☐ No

Do you often have an “eye opener” to avoid withdrawal symptoms? ☐ Yes ☐ No

How much alcohol are you consuming in a week, including beer and wine? _____

Have you ever been in treatment for alcohol/drug use? ☐ Yes ☐ No

If yes, please state where and dates of treatment:

_____

_____

Have you had any legal difficulties? ☐ Yes ☐ No

Patient Name:_____

In the **past year** have you used any of the following?

☐ Marijuana ☐ Cocaine/Crack ☐ Prescription Medications (abused)
☐ LSD ☐ Heroin ☐ Other _____
☐ Speed/Methamphetamines IV Drugs

Have you ever used any of the following?

☐ Marijuana ☐ Cocaine/Crack ☐ Prescription Medications (abused)
☐ LSD ☐ Heroin ☐ Other_____
☐ Speed/Methamphetamines IV Drugs

Do you have a past history or current problems of? (Please circle)

☐ Discipline problems in school
☐ Delinquency
☐ Running away from home
☐ Persistent lying
☐ Thefts
☐ Vandalism
☐ Frequent initiation of fights
☐ Alcohol or drug abuse
☐ School grades below expectations

Before age 15? ☐ Yes ☐ No
After age 18? ☐ Yes ☐ No

Additional Information:

_____
_____
_____
_____
_____

Patient Name:_____

PATIENT PROBLEM SURVEY

Below is a list of problems people sometimes have. Please read each one carefully and check which best describes how much that problem has bothered you ***during the past seven days***.

How much are you distressed by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
Crying easily	☐	☐	☐	☐	☐
Thoughts of ending your life	☐	☐	☐	☐	☐
Planning to end your life	☐	☐	☐	☐	☐
Blaming yourself for things	☐	☐	☐	☐	☐
Feeling depressed	☐	☐	☐	☐	☐
Loss of sexual interest or pleasure	☐	☐	☐	☐	☐
Change in appetite	☐	☐	☐	☐	☐
Feeling no interest in things	☐	☐	☐	☐	☐
Feeling hopeless about the future	☐	☐	☐	☐	☐
Feelings of worthlessness	☐	☐	☐	☐	☐
Feelings of guilt	☐	☐	☐	☐	☐
Change in sleep pattern	☐	☐	☐	☐	☐
History of hyperactivity	☐	☐	☐	☐	☐
Avoiding family, friends and other social activities	☐	☐	☐	☐	☐
Fears about gaining weight or becoming fat	☐	☐	☐	☐	☐
Restricting food to lose weight	☐	☐	☐	☐	☐
Vomiting or using laxatives to lose weight	☐	☐	☐	☐	☐
Impulsive behaviors	☐	☐	☐	☐	☐
Period of intense and/or excessive spending	☐	☐	☐	☐	☐
Periods of racing thoughts	☐	☐	☐	☐	☐
Repeated unpleasant thoughts that don't leave	☐	☐	☐	☐	☐
Trouble remembering things	☐	☐	☐	☐	☐
Difficulty concentrating	☐	☐	☐	☐	☐
Difficulty making decisions	☐	☐	☐	☐	☐
Having to repeat the same actions such as checking, counting or washing	☐	☐	☐	☐	☐
Trouble in your job	☐	☐	☐	☐	☐
Nervousness or shakiness inside	☐	☐	☐	☐	☐
Uncontrollable worrying	☐	☐	☐	☐	☐
Trembling	☐	☐	☐	☐	☐

Patient Name:_____

How much are you distressed by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
Heart pounding or racing	☐	☐	☐	☐	☐
Episodes of terror or panic	☐	☐	☐	☐	☐
Feeling that something bad is going to happen	☐	☐	☐	☐	☐
Feeling fearful of specific situations	☐	☐	☐	☐	☐
Feeling afraid to leave your house	☐	☐	☐	☐	☐
Uncomfortable around new people/situations	☐	☐	☐	☐	☐
Feeling easily annoyed or irritated	☐	☐	☐	☐	☐
Temper outbursts that you could not control	☐	☐	☐	☐	☐
Having urges to beat, injure or harm someone	☐	☐	☐	☐	☐
Feeling others are to blame for your troubles	☐	☐	☐	☐	☐
Feeling that you are watched or talked about by others	☐	☐	☐	☐	☐
The idea that someone else controls your thoughts	☐	☐	☐	☐	☐
Hearing voices that other people do not hear	☐	☐	☐	☐	☐
Other people being aware of your private thoughts	☐	☐	☐	☐	☐
Having thoughts that are not your own	☐	☐	☐	☐	☐
The idea that you should be punished for your sins	☐	☐	☐	☐	☐
The idea that something serious is wrong with your body	☐	☐	☐	☐	☐
Headaches	☐	☐	☐	☐	☐
Nausea or upset stomach	☐	☐	☐	☐	☐
Constipation or diarrhea	☐	☐	☐	☐	☐

Reviewed by:_____ **Date:** _____