Patient History Form

Date: _____

Patient Name: _____ Date of Birth: _____

Primary Care Physician: _____

Therapist/Counselor _____Therapist's Phone _____

What problem(s) are you seeking care for?

1. _____
2. _____
3. _____

What are your treatment goals?

_____

_____

_____

Current Symptoms: (please check all that apply)

- ❑ Sleep Pattern Disturbance
- ❑ Loss of Interest
- ❑ Concentration/Forgetfulness
- ❑ Depressed Mood
- ❑ Unable to enjoy activities
- ❑ Change in Appetite
- ❑ Excessive Guilt
- ❑ Fatigue
- ❑ Decreased Libido
- ❑ Increase Risky Behavior
- ❑ Decrease need for Sleep
- ❑ Racing Thoughts
- ❑ Impulsivity
- ❑ Excessive Energy
- ❑ Increased Irritability
- ❑ Crying Spells
- ❑ Avoidance
- ❑ Hallucinations
- ❑ Suspiciousness
- ❑ Excessive Worry
- ❑ Anxiety Attacks
- ❑ Other:
- ❑
- ❑

In Patient Psychiatric History

How many times: _____ Date of Last Stay: _____ Where: _____

Previous Psychiatrist Name: _____ Phone: _____

Family Psychiatric History: Has anyone in your family been diagnosed with or treated for: (please check all that apply)

- ❑ Depression
- ❑ Anxiety
- ❑ Anger
- ❑ Bipolar Disorder
- ❑ Suicidal
- ❑ Post-Traumatic Stress
- ❑ Alcohol Use
- ❑ Other Substance Use
- ❑ Schizophrenia
- ❑ Violence

Patient History Form

Past Medical History

Allergies: _____

List ALL current precription medications and how often you are taking them:

_____
_____
_____
_____
_____

Current over the counter medications or supplements:

_____
_____
_____
_____

Current Medical Conditions:

_____
_____
_____

Substance Use: Check if you have ever tried the following

- ❑ Stimulant (pills)
- ❑ Heroin
- ❑ LSD or Hallucinogens
- ❑ Methamphetamine
- ❑ Cocaine
- ❑ Cannabis/Marijuana: ( ) Recreational ( ) Medical
- ❑ Alcohol
- ❑ Ecstasy
- ❑ Prescription Medications
- ❑ Methadone
- ❑ Tranquilizer/Sleeping Pills
- ❑ Other:

Have you ever been treated for alcohol or drug use: ( ) Yes ( ) No
If yes, for which substance? _____
If yes, *when* and *where* did you receive treatment? _____

Cannabis/Marijuana Use:
Do you have a Medical Marijuana Card? ( ) Yes ( ) No
When and where was your medical marijuana card obtained? _____
How often do you use cannabis/marijuana? _____

Patient History Form

Alcohol Use:

How many days per week do you drink alcohol? _____
What is the least amount of alcohol do you drink in a day? _____
What is the greatest amount of alcohol do you drink in a day? _____
In the past three months, what is the largest amount of alcohol you have consumed in a day? _____
Have you ever felt you ought to cut down on your alcohol intake or drug use? ( ) Yes ( ) No
Have people annoyed you by criticizing your drinking or drug use? ( ) Yes ( ) No
Have you ever felt bad or guilty about your drinking or drug use? ( ) Yes ( ) No
Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hang over? ( ) Yes ( ) No
Do you think you may have a problem with alcohol or drug use? ( ) Yes ( ) No

Tobacco History

Have you ever used tobacco products? ( ) Yes ( ) No Currently? ( ) Yes ( ) No
How many packs per day on average? _____How many years? _____

Is there anything else you would like us to know? _____
_____
_____
_____
_____
_____
_____
_____

Patient Signature: _____ **Date:** _____

Guardian Signature (if under age 18) _____ **Date:**_____

Emergency Contact: _____ **Telephone Number:** _____