PATIENT HISTORY FORM

Patient Name: I look forward to your visit. I 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.					
Name	Occupation/Grade	Age	Relationship		
Family members not	living in the household (stepchile	dren, adult children, etc.):			
Name	Age	Relationship	Location		
Please list family m difficulties with drug of Family Member (Rela	or alcohol abuse:	emotional problems, psych Problem	iatric illness (including suicide) and/or Ongoing/Resolved (List One)		
Describe the problem	s that are causing you to seek h	nelp:			
When did the problen	n(s) begin?				

Have you ever seen a psychiatrist or therapist? Yes No If yes, with whom and for how long were you treated?					
What medications are	you currently taking?				
Medication	Frequency	Amount	For What		
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Have you ever had m	edication prescribed for psychia	tric or emotional difficulties? Ye	es No		
If yes, please list all s	uch medications, their dosages	and when you took them:			
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Have you had allergic	reactions or other problems wit	th medications? Yes No)		
If yes, please list the r	medication and the reaction or p	problem:			
What medical problem	ns do you have? Do you have a	a history of head injury?			

List type and dates of any med	lical hospitalizations and	l/or surgeries you have had:
Have you ever been hospitaliz	ed for psychiatric reason	ns? Yes No
If yes, please state when and	cause:	
Have you ever attempted suic	ide? Yes No	<u> </u>
If yes, how?		
When:		
Treatment received?		
Are you having thoughts of ha	rming yourself or others	such as your spouse or children? Yes No
How much caffeine do you ha	ve a day?	
Do you smoke? Yes N	lo	
Have you ever had problems	with drinking alcohol? Ye	es No
How much alcohol are you co	nsuming in a week, inclu	ding beer and wine?
Have you ever been in treatme	ent for alcohol/drug use?	Yes No
If yes, please state where and	dates of treatment:	
Have you had any legal difficu	Ities? Yes No	
Have you used or do you curr	ently use recreational dru	ugs? Please circle those you use or have used in the past:
Marijuana	Cocaine/Crack	Prescription Medications
LSD	Heroin	Other
Speed/Methamphetamines	IV Drugs	