**Patient History Information**

First Name Last Name MI

SSN DOB Age

Address City State ZIP

Email Address Pronouns\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone Cell Phone

Employer Work Phone

Occupation

Emergency Contact Name Relationship to Patient

Emergency Contact Phone Cell Phone

Primary Care MD Phone Number

Address City State ZIP

Psychiatrist Phone Number

Address City State ZIP

Referred By

Marital Status:

* Single
* Married How many times? How long?
* Divorced How many times? How long?
* Widow/Widower How many times? How long?
* Domestic Partnership or How many times? How long?

Cohabitation

Living Situation: Own Rent

* House
* Condominium
* Apartment
* Other

Please describe the reason for your visit:

Have you experienced similar or identical problems in the past? Yes No

Please explain

Have you ever been treated or hospitalized for psychiatric, emotional, behavioral, or substance abuse problems?

Yes No

Please list all circumstances, dates, and locations, and names of clinicians:

Please list all medications (including dosages) that you are currently taking:

Do you have any medication or other allergies? Yes No

Please List

Do you have a history of head injuries or seizures? Yes No

Please Explain

Do you have pain management issues? Yes No

Please Explain

Do you have a history of developmental issues? Yes No

Please Explain

Do you have any medical problems? Yes No

Please Explain

Have you ever been treated for drug or alcohol abuse or other addictions (food, gambling, sex, internet, etc.)? Yes No

Circle any of the following you have used in the past 30 days: tobacco, alcohol, marijuana, tranquilizers, sleeping pills, pain killers, heroin, cocaine/crack, amphetamines/speed, Benzodiazepines, Methadone, LSD, Ecstasy, inhalants

Have you ever experienced withdrawal symptoms? Yes No Blackouts? Yes No

Have you ever had a DUI? Yes No

Circle your current employment status: full time/part time unemployed

homemaker student

retired disabled

Are you having difficulties at work or concerns about your job? Yes No

Please Explain

Does anyone in your family have/had psychiatric, emotional, behavioral, or addiction problems? Yes No

Please Explain

Do you have difficulties or concerns about how you get along with other people? Yes No

Please Explain

Do you have any sexual orientation issues or concerns? Yes No

Please Explain

Do you have any legal problems? Yes No

Please Explain

Have you ever been a victim of abuse? Yes No

* physical
* emotional
* sexual

Please Explain

Have you experienced other traumas? Yes No

Please explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list all of your children, including their ages:

Please list everyone who currently lives with you and your relationship to them:

Are you, or anyone in your family adopted (if yes, please elaborate)

Please circle your level of education: Completed Grade / HS Diploma / GED / Some College / Technical School / College Degree / Graduate or Professional Degree(s)

 Area of interest/expertise/type of degree

Please explain any recent changes have you experienced in the following (continue on back if needed):

* Mood
* Sleep
* Concentration
* Energy
* Interest in things that you normally enjoy
* Appetite
* Libido
* Feelings of guilt
* Thoughts of hurting yourself/suicide
	+ If you have these thoughts now or have ever had them in the past, please indicate dates and circumstances

* + Has anyone close to you ever committed suicide or talked about hurting him or herself?

* Thoughts of hurting someone else