Patient Health History

Please complete and bring to your 1st appointment.

Patient Name:_____ **Marital Status:**_____

Person completing form (if other than patient):_____ **Relationship:**_____

Name of Guardian (if applicable): _____

Contact person in case of emergency: _____ **Relationship:**_____ **Phone #:**_____

Primary Care Physician: _____ **Date of Last Exam:** _____

Current Medical Condition(s): _____

_____

Any peri-natal or developmental abnormalities? No___ Yes___ (Please explain on back of form)

Are you currently taking any prescription or "over the counter" medication(s)? No___ Yes___

If Yes, please identify the name, current dosage, and date began for each: _____

_____

Do you have any allergies? No___ Yes___ If yes, please list: _____

_____

Have you received any Psychological/Psychiatric treatment before? No___ Yes___

If Yes, please show the total number of outpatient visits you have had: _____

What was your age at the first visit? _____

Have you had any inpatient/hospital treatment for mental health or substance abuse? No___ Yes___

[If Yes, please list facility(ies) date(s) and length(s) of stay(s)]: _____

_____

What caused you to get help now? _____

_____

_____

Do you smoke cigarettes? No___ Yes___ If yes, how many per day? _____

How much alcohol do you drink per week on average? _____ drinks per week

Have you had problems with your drinking (legal, health, work, relationship?)

No___ Yes___ If Yes, please explain: _____

_____

Please answer whether or not you are experiencing any of the following symptoms:

Suicidal Thoughts/Impulses	N____ Y____
Homicidal Thoughts/Impulses	N____ Y____
Appetite Problems	N____ Y____
Sleep Problems	N____ Y____
Physical Complaints	N____ Y____
Anger/Irritability	N____ Y____
Isolation/Social Withdrawal	N____ Y____
Anxiety/Panic	N____ Y____
Phobia	N____ Y____
Bingeing/Purging	N____ Y____
Poor Impulse Control	N____ Y____
Violence Toward Others	N____ Y____
Destruction of Property	N____ Y____
Strange or Unusual Behavior	N____ Y____
Confused or Irrational Thinking	N____ Y____
Bothersome Repetitive Thoughts or Behaviors	N____ Y____
Self-mutilation	N____ Y____