Patient Health History
Please complete and bring to your first appointment **DATE: ____________________**

Patient Name:____ **Date of birth:** _______________**Marital Status:**_______________________

Home #: ______________________________ **Work #**_______________________________ **Cell #** ________________________________

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

Name of Guardian (if applicable)or Parent (if under age 18) : ____

Emergency contact: ____**Relationship**:______________________ **Phone #:**______________

Primary Care Physician: ____ **Date of Last Exam**: _________________________

Physician address:______________________________________**City:**___________________________**State:**________**Zip:**_____________

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:

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