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 #:_____**

Date of Last Medical 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	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____