

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 ___