



## CONFIDENTIAL PATIENT HISTORY FORM

Date: _____/_____/_____
NAME: _____ Last First M. I.
Age: _____ Sex: <input type="checkbox"/> F <input type="checkbox"/> M Birth date: _____/_____/_____
How did you hear about this clinic?
Describe briefly your present symptoms:
Please list the names of other practitioners you have seen for this problem:
Psychiatric Hospitalizations (include where, when, & for what reason):
Have you ever had ECT? Have you had psychotherapy?

What are your treatment goals?

List three things you struggle with currently and hope to be able to do after therapy.

- 1.
- 2.
- 3.

CURRENT MEDICATIONS		
Drug allergies: <input type="checkbox"/> No <input type="checkbox"/> Yes To what?		
Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:		
Name of drug	Dose (include strength & number of pills per day)	How long have you been taking this?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

Please tell us about other medications, which you no longer take that caused significant side effects or simply did not relieve your symptoms.

- 1.
- 2.
- 3.
- 4.
- 5.

PAST MEDICAL HISTORY		
Do you now or have you ever had:		
<input type="checkbox"/> Diabetes <input type="checkbox"/> High blood pressure <input type="checkbox"/> High cholesterol <input type="checkbox"/> Hypothyroidism <input type="checkbox"/> Goiter <input type="checkbox"/> Cancer (type) _____ <input type="checkbox"/> Leukemia <input type="checkbox"/> Psoriasis <input type="checkbox"/> Angina <input type="checkbox"/> Heart problems	<input type="checkbox"/> Heart murmur <input type="checkbox"/> Pneumonia <input type="checkbox"/> Pulmonary embolism <input type="checkbox"/> Asthma <input type="checkbox"/> Emphysema <input type="checkbox"/> Stroke <input type="checkbox"/> Epilepsy (seizures) <input type="checkbox"/> Cataracts <input type="checkbox"/> Kidney disease <input type="checkbox"/> Kidney stones	<input type="checkbox"/> Crohn's disease <input type="checkbox"/> Colitis <input type="checkbox"/> Anemia <input type="checkbox"/> Jaundice <input type="checkbox"/> Hepatitis <input type="checkbox"/> Stomach or peptic ulcer <input type="checkbox"/> Rheumatic fever <input type="checkbox"/> Tuberculosis <input type="checkbox"/> HIV/AIDS
Other medical conditions (please list):		

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**PERSONAL HISTORY**

Were there problems with your birth? (specify)  
 Where were you born & raised?  
 What is your highest education?     High school     Some college     College graduate     Advanced degree  
 Marital status:  Never married     Married     Divorced     Separated     Widowed     Partnered/significant other  
 What is your current or past occupation?  
 Are you currently working? :     Yes     No    Hours/week \_\_\_\_\_    If not, are you  retired     disabled     sick leave?  
 Do you receive disability or SSI?     Yes     No    If yes, for what disability & how long? \_\_\_\_\_  
 Have you ever had legal problems? (specify)  
 Religion:

**FAMILY HISTORY**

	IF LIVING		IF DECEASED	
	Age (s)	Health & Psychiatric	Age(s) at death	Cause
Father				
Mother				
Siblings				
Children				

**EXTENDED FAMILY PSYCHIATRIC PROBLEMS PAST & PRESENT:**

Maternal Relatives:

Paternal Relatives:

## SYSTEMS REVIEW

In the past month, have you had any of the following problems?

### GENERAL

- Recent weight gain; how much\_\_\_\_\_
- Recent weight loss: how much\_\_\_\_\_
- Fatigue
- Weakness
- Fever
- Night sweats

### MUSCLE/JOINTS/BONES

- Numbness
- Joint pain
- Muscle weakness
- Joint swelling

Where?

### EARS

- Ringing in ears
- Loss of hearing

### EYES

- Pain
- Redness
- Loss of vision
- Double or blurred vision
- Dryness

### THROAT

- Frequent sore throats
- Hoarseness
- Difficulty in swallowing
- Pain in jaw

### HEART AND LUNGS

- Chest pain
- Palpitations
- Shortness of breath
- Fainting
- Swollen legs or feet
- Cough

### NERVOUS SYSTEM

- Headaches
- Dizziness
- Fainting or loss of consciousness
- Numbness or tingling
- Memory loss

### STOMACH AND INTESTINES

- Nausea
- Heartburn
- Stomach pain
- Vomiting
- Yellow jaundice
- Increasing constipation
- Persistent diarrhea
- Blood in stools
- Black stools

### SKIN

- Redness
- Rash
- Nodules/bumps
- Hair loss
- Color changes of hands or feet

### BLOOD

- Anemia
- Clots

### KIDNEY/URINE/BLADDER

- Frequent or painful urination
- Blood in urine

### Women Only:

- Abnormal Pap smear
- Irregular periods
- Bleeding between periods
- PMS

### PSYCHIATRIC

- Depression
- Excessive worries
- Difficulty falling asleep
- Difficulty staying asleep
- Difficulties with sexual arousal
- Poor appetite
- Food cravings
- Frequent crying
- Sensitivity
- Thoughts of suicide / attempts
- Stress
- Irritability
- Poor concentration
- Racing thoughts
- Hallucinations
- Rapid speech
- Guilty thoughts
- Paranoia
- Mood swings
- Anxiety
- Risky behavior

### OTHER PROBLEMS:

### WOMENS REPRODUCTIVE HISTORY:

Age of first period:

# Pregnancies:

# Miscarriages:

# Abortions:

Have you reached menopause? Y / N At what age?

Do you have regular periods? Y / N

SUBSTANCE USE					
DRUG CATEGORY (circle each substance used)	Age when you first used this:	How much & how often did you use this?	How many years did you use this?	When did you last use this?	Do you currently use this?
<b>ALCOHOL</b>					Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>CANNABIS:</b> Marijuana, hashish, hash oil					Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>STIMULANTS:</b> Cocaine, crack					Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>STIMULANTS:</b> Methamphetamine—speed, ice, crank					Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>AMPHETAMINES/OTHER STIMULANTS:</b> Ritalin, Benzedrine, Dexedrine					Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>BENZODIAZEPINES/TRANQUILIZERS:</b> Valium, Librium, Halcion, Xanax, Diazepam, "Roofies"					Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>SEDATIVES/HYPNOTICS/BARBITURATES:</b> Amytal, Seconal, Dalmane, Quaalude, Phenobarbital					Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>HEROIN</b>					Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>STREET OR ILLICIT METHADONE</b>					Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>OTHER OPIOIDS:</b> Tylenol #2 & #3, 282'S, 292'S, Percodan, Percocet, Opium, Morphine, Demerol, Dilaudid					Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>HALLUCINOGENS:</b> LSD, PCP, STP, MDA, DAT, mescaline, peyote, mushrooms, ecstasy (MDMA), Special K, nitrous oxide					Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>INHALANTS:</b> Glue, gasoline, aerosols, paint thinner, poppers, rush, locker room					Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>OTHER:</b> specify) _____ _____ _____					Yes <input type="checkbox"/> No <input type="checkbox"/>