Health History Form

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Name:_____ Date:_____

Primary Care Physician:_____
Telephone #:_____

Primary reason you are seeking treatment at this time
_____
_____

Have you ever engaged in therapy before? Y / N
Worked with a psychiatrist before? Y / N

If psychiatric meds were ever prescribed-please list those for which you have had trials, the reason(s) started and the reason(s) stopped:
_____
_____
_____
_____
_____

Medical History:
List any medical problems/meds prescribed:
_____
_____
_____
_____
_____
_____

Do you have a history of Seizures?
_____

Have you ever lost consciousness?

_____

Current Medications, physical and psychiatric please (or bring in full list, or bottles):

_____
_____
_____
_____
_____

Medication
Allergies:_____

Hospitalizations (Medical, Psychiatric, Substance related) Please give hospital/center and year:

_____
_____
_____

Do you:
Smoke Y / N? If yes, packs per day/number of years____/____
Drink alcohol Y / N? If yes, number of drinks/week (one beer=one "drink")_____
For how long? _____
Use drugs Y / N? If yes, indicate which drug/how often/amount:

_____
_____
_____

Ever participate in Drug/alcohol rehabilitation program? Y / N
If yes, please explain_____

_____
_____
_____

Family history of:
Mental illness? _____Yes _____No
If yes, explain briefly:_____
Substance abuse? _____Yes _____No
If yes, explain briefly:_____
Suicide? _____Yes _____No
If so, please elaborate briefly:_____
Violent behavior? _____Yes _____No
If so, please elaborate briefly:_____

Is there anything else you would like me to know prior to seeing you?

_____
_____
_____
_____
_____