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Medical and Psychiatric History Form

Name:_____Date_____

Preferred name /pronouns:_____

Date of Birth_____Primary Care_____

Therapist/Counselor_____Therapist's Phone_____

Preferred Pharmacy_____

What are the problem(s) for which you are seeking help?

1_____

2_____

3_____

What are your treatment goals?

_____

_____

_____

Current Symptoms Checklist:

( ) Depressive mood	( ) Racing thoughts	( ) Excessive Worry
( ) Unable to enjoy activities	( ) Impulsivity	( ) Anxiety attacks
( ) Sleep disturbance	( )Increase Risky Behavior	( ) Suicidal thoughts
( ) Loss of Interest	( ) Excessive energy	( ) Poor energy
( ) Change in Appetite	( ) Increased Irritability	( ) Hallucinations
( ) Concentration/Forgetfulness	( ) Crying spells	( )_____
( )_____	( )_____	( )_____

Medical History

Current medical problems:

Past Medical Problem, non-psychiatric hospitalizations or surgeries

Allergies_____

Current Weight: _____Height_____

Have you ever had an EKG? ( )Yes ( )No If yes, when_____

Was the EKG ( ) Normal ( )Abnormal or ( )Unknown

List all prescription medications and how often you take them: (If none, write none)

Medication Name Total Dose Estimated Start Date

Current over the counter medications or supplements:

Put a check mark for all that apply to a family member:

Personal/Family Medical History	Family	Which Family Member
Anemia		
Liver Disease		
Kidney Disease		
Heart Problems		
High Blood Pressure		
Asthma/Respiratory Problems		
Stomach or Intestinal Problems		
Cancer		
Fibromyalgia		
Seizure/Epilepsy		
Chronic Pain		
High Cholesterol		
Head Trauma/Concussion		
Diabetes		
Other:		

When your mother was pregnant with you, were there any complications during the pregnancy, birth or developmental in the first few years of life:

_____

_____

_____

_____

REVIEW OF SYSTEMS

For new patients, established patients who may be having a new problem, or our patients who we haven't seen for a while, we need to update our records as to your general medical health. In each area, if you are not having any difficulties, please check "No Problems." If you are experiencing any of the symptoms listed, **PLEASE CIRCLE THE ONES THAT APPLY**, or explain any that may not be listed. If you have any questions about this, please ask one of the technicians, or your doctor.

Const. (Health in General) ❑ No Problems Lack of energy, unexplained weight gain or weight loss, loss of appetite, fever, night sweats, pain in jaws when eating, scalp tenderness, prior diagnosis of cancer. Other: _____

Ears, Nose, Mouth & Throat ❑ No Problems Difficulty with hearing, sinus problems, runny nose, post-nasal drip, ringing in ears, mouth sores, loose teeth, ear pain, nosebleeds, sore throat, facial pain or numbness. Other: _____

C-V (Heart & Blood Vessels) ❑ No Problems Irregular heartbeat, racing heart, chest pains, swelling of feet or legs, pain in legs with walking. Other: _____

Resp. (Lungs & Breathing) ❑ No Problems Shortness of breath, night sweats, prolonged cough, wheezing, sputum production, prior tuberculosis, pleurisy, oxygen at home, coughing up blood, abnormal chest x-ray. Other: _____

GI (Stomach & Intestines) ❑ No Problems Heartburn, constipation, intolerance to certain foods, diarrhea, abdominal pain, difficulty swallowing, nausea, vomiting, blood in stools, unexplained change in bowel habits, incontinence. Other: _____

GU (Kidney & Bladder) ❑ No Problems Painful urination, frequent urination, urgency, prostate problems, bladder problems, impotence. Other: _____

MS (Muscles, Bones, Joints) ❑ No Problems Joint pain, aching muscles, shoulder pain, swelling of joints, joint deformities, back pain. Other: _____

Integ. (Skin, Hair & Breast) ❑ No Problems Persistent rash, itching, new skin lesion, change in existing skin lesion, hair loss or increase, breast changes. Other: _____

Neurologic (Brain & Nerves) ❑ No Problems Frequent headaches, double vision, weakness, change in sensation, problems with walking or balance, dizziness, tremor, loss of consciousness, uncontrolled motions, episodes of visual loss. Other: _____

Psychiatric (Mood & Thinking) ❑ No Problems Insomnia, irritability, depression, anxiety, recurrent bad thoughts, mood swings, hallucinations, compulsions. Other: _____

Endocrinologic (Glands) ❑ No Problems Intolerance to heat or cold, menstrual irregularities, frequent hunger/ urination/thirst, changes in sex drive. Other: _____

Hematologic (Blood/Lymph) ❑ No Problems Easy bleeding, easy bruising, anemia, abnormal blood tests, leukemia, unexplained swollen areas. Other: _____

Allergic/Immunologic ❑ No Problems Seasonal allergies, hay fever symptoms, itching, frequent infections, exposure to HIV. Other: _____

Your Past Psychiatric Treatment History

	Dates	Reason	Provider/Organization
Outpatient Treatment			
Partial Hospitalization Program			
Rehabilitation/detox			
Inpatient			

Past Medications: Put a check mark on any medication you have tried in the past

Antidepressants	Antipsychotic
Prozac (Fluoxetine)	Seroquel (Quetiapine)
Zoloft (sertraline)	Zyprexa (Olanzapine)
Luvox (Fluvoxamine)	Geodon (Ziprasidone)
Paxil (Paroxetine)	Abilify (Aripiprazole)
Celexa (Citalopram)	Clozaril (Clozapine)
Lexapro (Escitalopram)	Haldol (Haloperidol)
Effexor (Venlafaxine)	Prolixin (Fluphenazine)
Cymbalta (Duloxetine)	Risperdal (Risperidone)
Wellbutrin (Bupropion)	Latuda (Lurasidone)
Remeron (Mirtazapine)	Vraylar (cariprazine)
Anafranil (Clomipramine)	Invega (Paliperidone)
Pamelor (Nortriptyline)	Other:
Elavil (Amitriptyline	
Viibryd (vilazadone)	
Trintellix (vortioxetine)	
Trazodone	
Other:	

Anti-Anxiety	Mood Stabilizers
Xanax (Alprazolam)	Tegretol (carbamazepine)
Ativan (Lorazepam)	Lithium
Klonopin (Clonazepam)	Depakote (Valproate)
Valium (Diazepam)	Lamictal (Lamotrigine)
Buspar (Buspirone)	Topamax (Topiramate)
Other:	Neurontin (gabapentin)
	Trileptal (Oxcarbazepine)
	Other:

ADHD Medication	Sedative/Hypnotic
Adderall (amphetamine salt)	Ambien (Zolpidem)
Concerta (Methylphenidate)	Sonata (Zaleplon)
Ritalin (Methylphenidate)	Rozerem (Ramelteon)
Strattera (Atomoxetine)	Restoril (Temazepam)
Vyvanse	Lunesta (Eszopiclone)
Guanfacine (Intuniv)	Other:
Clonidine (Catapress)	
Other:	

Your History of Substance Use:

What	How often	How Much	Last Used
Alcohol			
Nicotine			
Marijuana			
Heroine			
Cocaine			
Other:			

Your Family's Psychiatric History:

Has anyone in your **family** been diagnosed or treated for:

Problem	Yes/no	Who	
Bipolar Disorder			
Schizophrenia			
Depression			
PTSD			
Alcohol use disorder			
Drugs			
ADHD			
Violence			
Other:			

I attest that all the information on this form is accurate to the best of my knowledge.

_____

Patient

_____

Signature of patient, parent or guardian