

# Patient Health History

Please complete and bring to your 1<sup>st</sup> appointment.

Patient Name: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Person completing form (if other than patient): \_\_\_\_\_ Relationship: \_\_\_\_\_

Name of Guardian (if applicable): \_\_\_\_\_

Contact person in case of emergency: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Date of Last 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 .....            | N___ Y___ |
| Homicidal Thoughts/Impulses .....           | N___ Y___ |
| Appetite Problems .....                     | N___ Y___ |
| Sleep Problems .....                        | N___ Y___ |
| Physical Complaints .....                   | N___ Y___ |
| Anger/Irritability .....                    | N___ Y___ |
| Isolation/Social Withdrawal .....           | N___ Y___ |
| Anxiety/Panic .....                         | N___ Y___ |
| Phobia .....                                | N___ Y___ |
| Bingeing/Purging .....                      | N___ Y___ |
| Poor Impulse Control .....                  | N___ Y___ |
| Violence Toward Others .....                | N___ Y___ |
| Destruction of Property .....               | N___ Y___ |
| Strange or Unusual Behavior .....           | N___ Y___ |
| Confused or Irrational Thinking .....       | N___ Y___ |
| Bothersome Repetitive Thoughts or Behaviors | N___ Y___ |
| Self-mutilation .....                       | N___ Y___ |