REASON FOR CONSULTATION: _____

PAST PSYCHIATRIC HISTORY:

Are you currently seeing a psychiatrist? □ Y □ N Name:_____ Ph:_____

For what problems? Since when?_____

Are you currently seeing a therapist? □ Y □ N Name:_____ Ph:_____

For what problems? Since when?_____

Prior mental health treatment? □ Y □ N At what age initially? _____

Please list names of Providers:_____

_____

For what problems? How was it helpful?_____

_____

Psychiatric Hospitalizations: □ Y □ N # times?_____ What ages:_____

Reason for stay? 5150 hold? _____

Prior suicide attempt(s) □ Y □ N # times? _____ What age(s)? _____

What were the circumstances?

_____

_____

Prior or on-going self injury? □ Y □ N Describe_____

_____

Prior or on-going eating disorder? □ Y □ N

Describe_____

_____

Prior attempts to seriously harm someone? □ Y □ N Describe_____

_____

Impulsive nicotine use per day? □ Y □ N # of times daily _____

Impulsive, addictive behavior problems? □ Y □ N Describe_____

_____

PAST PSYCHIATRIC MEDICATIONS: *if possible, include year, dose, duration, effects, side effects*

_____

_____

CURRENT MEDICATIONS: *Please include doses, supplements and vitamins*

_____ _____

_____ _____

_____ _____

_____ _____

ALLERGIES: Y□ N□ List _____ **PREFERRED PHARMACY:**_____

MEDICAL HISTORY: Weight:_____ Height: _____

Max. Weight:_____ Min. Post-Puberty Weight: _____

Primary Care Physician: _____ Phone:_____

Specialists:_____

Medical Problems: E.G. DIABETES, HIGH BLOOD PRESSURE, HIGH CHOLESTEROL, THYROID, HEART, STROKE, CANCER:

□ Y □ N _____

Prior seizures or head trauma(s): □ Y □ N Please List

_____

Prior surgeries or hospitalizations: □ Y □ N

Please List: _____

WOMAN:

Number of pregnancies? _____ # Abortions/Miscarriages/stillbirths _____

History of post-partum depression? □ Y □ N Perimenopause/menopause □ Y □ N

Do you regularly use birth control? □ Y □ N

Please list current method of birth control: _____

ALCHOL AND DRUG HSITORY: *Please describe substances used including alcohol, marijuana, opiates, prescription pain/anxiety/sleeping pills, methamphetamines, cocaine/crack, hallucinogens, inhalants, ecstasy, PCP, steroids, spice, bath salts. List age started/ended, benefits/adverse effects.*

_____

_____

_____

Have you ever tried to cut down on alcohol /drug use? □ Y □ N

Felt guilty about your use? □ Y □ N

Have you every used alcohol/drugs the first thing in the morning? □ Y □ N

Have you ever experienced withdrawal symptoms from alcohol/drugs □ Y □ N

Have you ever felt annoyed by criticism about your use? From who? □ Y □ N

_____

Did you experience any negative consequences as a result of alcohol/drug use? □ Y □ N

e.g. health, family, friends, work, legal, DUI's. Please list below.

_____

_____

Have you attended 12 step meetings or rehabilitation programs? □ Y □ N

Please list and include your age at time you attended: _____

_____

Periods of heaviest use/sobriety: _____

Nicotine use per day:_____ Caffeine use per day: _____

WORK HISTORY:

□ Full time □ Part Time – Hours per week ____ □ Stay at home □ Unemployed □ Retired

□ Disabled

Employer Name : _____Position:_____

How long have you worked at this job? _____ Are you satisfied with this job? □ Y □ N

Prior occupations? At what ages? Any difficulties? _____

_____

_____

SOCIAL HISTORY:

Where were you born? _____ Where did you grow up?_____

Marital Status: □ Single □ Married #___ □ Separated □ Divorced □ Widowed/Widower

Who lives in your household: _____

Do you have children? □ Y □ N Ages/gender_____

Sexual Identification/orientation:_____

Satisfaction with current relationship:_____

Is there any emotional/verbal/physical abuse in the relationship? □ Y □ N

Education- Highest grade completed:_____ Degree? _____

How did you do in school? Difficulties in any areas?_____

_____

_____

Did you serve in the military? □ Y □ N

Branch? _____ Combat? □ Y □ N

Describe current stressors in your life? _____

_____

_____

_____

Describe your support system:

_____

_____

_____

As a child, what was your relationship like with your parents/caregivers? Who did you go to with problems?

_____

_____

_____

_____

List siblings, if any, in order of birth:

_____

_____

Any childhood or adult abuse (emotional/physical/sexual) or neglect?

_____

_____

_____

LEGAL HISTORY:

Were you ever arrested as a juvenile? Please describe below. □ Y □ N

_____

_____

Have you been arrested as an adult? Please describe below. □ Y □ N

_____

_____

Have you served time in Jail or prison? □ Y □ N

Reason?_____

_____

Have you ever sued anyone? Number of times: _____ □ Y □ N

FAMILY HISTORY:

Is there any history of mental illness in your immediate and extended biological family? e.g. depression, bipolar disorder, anxiety, OCD, ADHD, schizophrenia, suicide, addiction?

_____

_____

_____

Any medical illnesses in your family? e.g. heart disease, hypertension, diabetes, thyroid disease, high cholesterol, strokes, cancer, dementia? If so, who?

_____

_____

_____

SIGNATURE: **DATE:**

_____ _ _____