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PATIENT INFORMATION **TODAY'S DATE**: _____

Patient's Name: _____ Sex: □ Male □ Female

Date of Birth: _____ Age: _____ Marital Status: _____

Home Address_____City_____State____Zip_____

Home Phone: (_____) _____ Cell Phone: (_____) _____

Occupation: _____ Work/School Phone: (_____) _____

Where can we leave confidential messages: □ home □ work □ cell □ email □ other _____

Employer/School Address:_____

E-mail Address:_____ Driver's License Number:_____ SS#_____ - _____ - _____

How were you referred to my practice?: _____

RESPONSIBLE PARTY and SPOUSE'S INFORMATION

Person Responsible for payment: □ self □ spouse □ parent □ other _____

Responsible Party: _____ SS#_____ - _____ - _____ Date of Birth: _____Age: _____

Home Address: _____

Home Phone: (_____)_____ Occupation:_____

Employer: _____Work Phone: (_____)_____

Employer Address: _____ Driver's License No.:_____

Spouse's Name: _____ Emergency Contact: _____

WHY DID YOU SEEK THE EVALUATION AT THIS TIME? What are your goals in being here?

_____

_____

MEDICAL HISTORY

Please list current medications/supplements/vitamins/herbs: _____

_____

_____

_____

Allergies/drug intolerances (describe):_____

Past medical problems/surgeries: _____

_____

Primary Care Physician (Name/Phone):_____

Any history of head trauma, concussion or significant accidents? (describe):_____

_____

Ever any seizures or seizure like activity?_____

Prior hospitalizations (place, cause, date, outcome): _____

Are you pregnant? □ Yes □ No Planning to become pregnant? □ Yes □ No Currently nursing an infant? □ Yes □ No

Do you use birth control? □ Yes □ No What type? _____Are you satisfied with your sex life? □ Yes □ No

Do you exercise? □ Yes □ No Type and frequency: _____Present Height _____ Present Weight _____

PSYCHIATRIC HISTORY

Please list all medications/supplements taken alone and all medications taken in combination; including

dosages, effectiveness and any side-effects.) *If you need more room, please attach another sheet.*

Date Taken	**Medication** ***Individual or Combinations*** ***Dosage(s) and time(s) taken per day***	**Effectiveness**	**Side-Effects/Problems**

For prior psychotherapy, please provide dates seen, therapist name, and what was or was not helpful:

_____

_____

_____

Please provide dates, location, and outcome of any psychiatric hospitalizations: _____

_____

_____

SOCIAL HISTORY

Current Life Stresses (include anything that is currently stressful for you, examples include relationships, job, school, finances, children)_____

_____

_____

_____

Prenatal and birth events:

Pregnancy complications (bleeding, excess vomiting, medication, infections, x-rays, smoking, alcohol/drug use, etc_____

Any birth problems, trauma, forceps or complications? _____

Sleep behavior: sleepwalking, nightmares, recurrent dreams, trouble falling asleep or waking up? _____

_____

_____

School History: Last grade completed _____ Last school attended _____

Any behavior or learning problems in school? _____

Employment History: (summarize jobs you've had, list most favorite and least favorite)

_____

_____

Any work-related problems?_____

Ever Any Legal Problems/Criminal Charges? _____

Are you currently involved in any litigation? _____

Any history of suicide attempts/violent behavior? _____

Do you have access to firearms? □ Yes □ No

Alcohol and Drug History: (Please list age started and types of substances used through the years and any current usage. Also, describe how each of these substances made you feel; what benefit you got from them.).

These include alcohol (hard liquor, beer, wine), marijuana or hash, prescription tranquilizers or sleeping pills, inhalants (glue, gasoline, cleaning fluids, etc.), cocaine or crack, amphetamines, steroids, opiates (heroin, codeine, morphine or other pain killers), barbiturates, hallucinating drugs (LSD, mushrooms), PCP.

_____
_____
_____
_____

Do you or have you ever experienced withdrawal symptoms from alcohol or drugs?_____
Has anyone told you they thought you had a problem with drugs or alcohol?_____
Have you ever felt guilty about your drug or alcohol use? _____
Have you ever felt annoyed when someone talked to you about your drug or alcohol use? _____
Have you ever used drugs or alcohol first thing in the morning?_____
Caffeine use per day (caffeine is in coffee, tea, sodas, chocolate)_____
Nicotine use per day, past and present, (nicotine is in cigarettes, cigars, tobacco chew) _____
Have you been involved in any 12 step programs (AA, NA, etc)? _____

FAMILY HISTORY

Family Structure (who lives in your current household, please give ages and your relationship to each):

_____
_____

Significant Developmental Events (include marriages, separations, divorces, deaths, and any traumatic history)_____
_____
_____

Natural Mother's History: age_____ occupation _____
School: highest grade completed _____ Medical Problems _____
_____

Has mother ever sought psychiatric treatment? Yes ___ No ___ If yes, for what purpose? _____
_____
Mother's alcohol/drug use history _____
_____

Have any of your mother's blood relatives ever had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalizations? (specify)
_____
_____

Natural Father's History: age_____ occupation _____
School: highest grade completed _____ Medical Problems _____
_____

Has father ever sought psychiatric treatment? Yes ___ No ___ If yes, for what purpose?_____
_____
Father's alcohol/drug use history _____
_____

Have any of your father's blood relatives ever had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalizations? (specify)
_____
_____

Siblings (names, ages, problems, strengths, relationship to patient)_____

_____

_____

Children (names, ages, problems, strengths)_____

_____

_____

Do you have any religious affiliation or **spiritual practices?**

_____

_____

Have any of your blood relatives experienced any of the following illnesses listed below? Please check the diseases and beside them, write which relative had the illness (i.e. mother, father, brother, sister, uncle, cousin, etc.).

□ Depression _____

□ Bipolar disorder/manic-depression _____

□ Alcoholism/drug abuse _____

□ Severe trauma _____

□ ADHD/learning disorders _____

□ Attempted or completed suicide _____

□ Anorexia/bulimia _____

□ Severe obesity _____

□ Anxiety/nerves _____

□ Epilepsy/seizures _____

□ High blood pressure_____

□ Diabetes _____

□ Cancer _____

□ Schizophrenia _____

□ Alzheimer's or Parkinson's disease _____

□ Psychiatric hospitalization _____